

# 2025 MEMBER GUIDE

[www.pggmeds.co.za](http://www.pggmeds.co.za)



The PG Group Medical Scheme is managed by a Board of Trustees, whose primary objective is to look after the interest 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 (CMS).

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.

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.

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 this guide, the rules shall prevail. You may request a copy of the rules from the Scheme.



# CONTENTS

Membership	1
Glossary	2
Online member portal and mobile app	6
Netcare 911 emergency services	7
Managed healthcare programmes	8
▶ Integrated Care Programme	8
▶ Renal Care Management Programme	8
▶ Oncology Risk Management Programme	8
▶ YourLife Programme (HIV management)	8
▶ Palliative Care Programme	8
▶ Maternity Programme	8
Belly Babies online support	8
▶ Medicine Risk Management (MRM) Programme	9
Chronic medication	9
Chronic disease list (CDL)	9
Acute medication	10
Generic medication	10
Prescribed minimum benefit (PMB) list	10
Pre-authorisation for hospitalisation	11
Motor vehicle accidents (MVAs) and injuries	12
Tips to combat high healthcare costs	12
Claims procedure	13
Scheme exclusions	14
Underwriting	15
Medical savings account (MSA)	16
Preferred Provider Negotiators (PPN) – Optical benefits	17
Dental Information Systems (DENIS) – Dental benefits	18
Wellness benefits	19
Additional preventative screening tests covered at no cost to you	21
2025 benefits	22
2025 contributions	25
Complaints process	26
Important contact details	27
Protection of Personal Information	28



# 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 dependants 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 their 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 131 of 1998 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 (HR) 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 HR 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 may you register as a dependant?

You may 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 HR department to advise the Scheme of any changes to your personal details, including:

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

A doctor usually prescribes acute medication to alleviate the symptoms of an acute illness or condition, for example antibiotics to treat an infection 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 23 years and older is regarded as an adult dependant.

### **Ambulance services**

This includes all medically equipped transport, like ambulances or helicopters, used 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 line 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.

### **Chronic conditions**

These are illnesses or conditions requiring medication for prolonged periods of time. The Medical Schemes Act 131 of 1998 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 and cholesterol. The diagnoses, treatment and medical management of the CDL conditions are covered according to the Scheme algorithms.

### **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 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. However, it should be noted that not all conditions necessitating treatment for more than three months may be termed as 'chronic' – 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 Medicine Risk Management (MRM) Programme and the medication is included in the list of chronic medication.

# GLOSSARY (CONTINUED)

## **Claim**

After you have received medical treatment, you or your healthcare provider (general practitioner (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 may pay the account from your own pocket and then claim it back from the Scheme. Please send us the detailed account and proof of payment for reimbursement. Refer to page 13 for details of the claims procedure.

## **Clinical guidelines, algorithms and protocols**

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

## **Computed tomography (CT/CAT) and magnetic resonance imaging (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.

## **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.

## **Day-to-day benefits**

You and your dependants may spend a certain maximum amount of money in a benefit year for primary healthcare services that do not require hospitalisation.

## **Dental benefits**

These include a wide range of different dental treatments and procedures – please refer to the **DENIS dental benefit information guide** on the website at [www.pggmeds.co.za](http://www.pggmeds.co.za) (Home or Publications pages).

## **Dependant**

A dependant includes your spouse or partner and any dependent children who are registered as members of the Scheme.

## **Emergency medical condition**

An emergency medical condition is the sudden and unexpected onset of a health condition or injury 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 according to Scheme protocols.

## **Exclusions**

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

## **Formulary (list of approved 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 contains exactly the same active ingredients, strength and formulation as their brand-name/patented equivalents. The same or another pharmaceutical company may produce the same medication once the patent on the original brand-name product has expired. As a result, the generic medication is usually more affordable.

## **HIV**

The human immunodeficiency virus (HIV) is a virus that attacks the body's immune defence system, weakening it, which makes it easier to get ill with other conditions, such as tuberculosis (TB), infections and even some cancers.

## GLOSSARY (CONTINUED)

### **Inception/joining/starting date**

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

### **International Classification of Diseases 10th Revision (ICD-10) codes**

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 from 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 with a break in coverage of more than three consecutive months since 1 April 2001.

### **Managed healthcare**

Managed healthcare aims to promote the rational, cost-effective and appropriate use of healthcare resources. This holistic approach focusses on your medical conditions, using all the cost elements involved. It includes counselling and education, behaviour modification and case management. You may have to register on one of the managed healthcare programmes to receive this benefit. 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 further assists in the appropriate management of conditions that require chronic medication, such as cancer, renal care and mental health.

### **Medical savings account (MSA)**

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

### **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 18 years is regarded as a minor.

### **Network healthcare providers**

This refers to a group or individual healthcare providers or healthcare facilities contracted to the Scheme to provide quality healthcare services to our members according to a defined reimbursement structure. The Scheme may have negotiated preferential rates with a specific healthcare provider in offering benefits. You may be limited to using network healthcare providers (i.e. doctors, pharmacies, hospitals, etc.).

### **Oncology**

This field of medicine involves the treatment of cancer. It may include medication, chemotherapy and radiotherapy. For access to additional benefits to manage your condition and treatment, please register on the Oncology Risk Management Programme. All members diagnosed with cancer have free access to the programme.

### **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)/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 may be treated effectively with medication available from your pharmacy without a doctor's prescription.

### **Pre-authorisation**

Pre-authorisation is the process of informing the Scheme of a procedure/treatment that often 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 or authorisation for a procedure/treatment; however, it is not a guarantee of payment.

# GLOSSARY (CONTINUED)

## **Pre-existing condition**

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

## **Prescribed minimum benefits (PMBs)**

Prescribed minimum benefits (PMBs) refer to medical conditions that the Scheme is legally required to cover according to the Medical Schemes Act 131 of 1998. All South African registered medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- any emergency medical condition;
- a limited set of 270 medical conditions called diagnosis and treatment pairs (DTPs); and
- 26 chronic conditions that make up the chronic disease list (CDL) – see page 9.

For more information on PMBs, please visit the Council for Medical Schemes (CMS) website at [www.medicalschemes.com](http://www.medicalschemes.com).

## **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 additional chronic conditions, as specified by the Scheme.

## **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, you would only receive pro rata benefits for the remaining nine months of the year. 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 reflects the reasons for payment discrepancies. They usually appear on your claims statements, which are sent to you monthly if you have submitted any claims.

## **Scheme rate/tariff**

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

## **Single exit price (SEP)**

The single exit price (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 101 of 1965, as amended.

## **South African Medical Association (SAMA) rates**

This is the tariff structure that SAMA deems to be appropriate for their registered healthcare providers. It is a guideline for healthcare providers in private practice regarding the fees that they are allowed to charge for their services.

## **To-take-out (TTO) medication**

TTO medication is medication prescribed to you or your dependants after being hospitalised, which you are allowed to take home upon discharge.

## **Therapeutic reference pricing**

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

## **Underwriting**

Depending on your medical scheme history, the Scheme may apply underwriting to your membership upon joining. This means that the Scheme is allowed to impose waiting periods and/or a late-joiner penalty.

## **Waiting period (condition-specific)**

Depending on your 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 as defined above. 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 PMB conditions in line with the Medical Schemes Act 131 of 1998.

# ONLINE MEMBER PORTAL AND MOBILE APP

## Online member portal

Access the Scheme's web-based self-help portal to view and update your personal medical Scheme information. Visit [www.pggmeds.co.za](http://www.pggmeds.co.za) to log in.

The following quick guide will help you to register on the Scheme's online member portal.

1. Visit the PG Group Medical Scheme website at [www.pggmeds.co.za](http://www.pggmeds.co.za) and click on **Sign in**.
2. Choose the Member login option to be directed to the Member Sign In login screen.
3. On the Member Sign In login screen, new and existing users must select **Register A User** to create an online profile.
4. Complete your details under **New User Registration** and click on 'Register'.
5. You will receive a one-time password (OTP) by email or SMS. Enter your username and OTP on the **Verify Your Account** screen.

## Updating your contact details

Use the member portal to update your contact details, such as your contact number, email address or postal address. Simply go to **Edit Profile** to update your information and that of your dependants.

## Viewing your benefits

On the **Benefits** tab, you have access to view your MSA balances, chronic medication benefits and you may check what benefits you have used and what is still available within the benefit year.

## View and query claims

The **Claims** screen allows you to view your claims history, refunds and lots more. You may either download documents or even take a screenshot of the current claims being processed if you wish to have a record of it or to query any of the amounts your doctor has charged before the payment is made.

## Electronic Health Record

The **Electronic Health Record** refers to you and your dependants' clinical or medical data, which includes information relating to your healthcare providers, diagnoses, treatments, prescription medication, laboratory tests, hospitalisation, treatment plans and chronic registration.

## Provider search

Find any healthcare provider, such as a GP, dentist or a specialist using the **Provider Search** function. It contains the healthcare provider's name, practice number, contact details and their practice physical address.

## Mobile app

The PG Group Medical Scheme mobile app allows quick access to your medical scheme information in the palm of your hands – faster and more efficiently. For example, you may view the status of your medical scheme claims and authorisations in real time, without having to contact the call centre.

Use your existing username and password to log in (this is the same details that you would use to log in to the member portal). If you don't have a username and password, you will need to register for one by following the steps in our **Mobile app manual** or contacting the Customer Care Centre for assistance.

You may also access the **Mobile app manual** on the website homepage.

Download the PG Group Medical Scheme mobile app from Google Play or the Apple App Store.

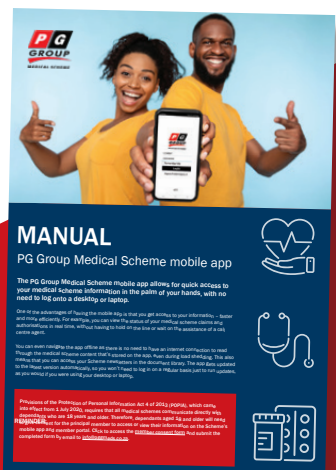


Please contact our Customer Care Centre should you require assistance or support to log in to either the member portal or the mobile app.

☎ 0860 005 037

📞 0860 005 037

✉ [info@pggmeds.co.za](mailto:info@pggmeds.co.za)



# 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 may be dispatched, if required. Simply dial **082 911** so that you and your dependants will 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 from which you are calling.
- 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 hang up 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 services 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 nurses via the Netcare 911 24-hour emergency operations centre and in line with current clinical best practice.
- **Emergency medical response by road or air from the scene of a 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

Emergencies/Health-on-Line	<b>082 911</b>
Central Customer Service Centre	<b>010 209 8911</b>
Email	<a href="mailto:customer.service@netcare.co.za">customer.service@netcare.co.za</a>
Website	<a href="http://www.netcare911.co.za">www.netcare911.co.za</a>



# MANAGED HEALTHCARE PROGRAMMES

The Scheme has contracted with the administrator, Momentum Health, to provide managed healthcare programmes, which offers many benefits.

Members may register for these managed healthcare programmes to access benefits, and your treating doctors may collaborate with our team of clinical experts for the appropriate treatment of your chronic conditions. Please contact **0860 005 037** and follow the voice prompts for more information and to register on these programmes.

## Integrated Care Programme

The programme is uniquely tailored to the specific healthcare needs of registered members, based on the latest research and specialised knowledge to assist in actively managing their conditions, such as heart disease, diabetes, respiratory conditions and mental health.

## Renal Care Management Programme

All patients with impaired kidney/renal function need to register on the programme to ensure effective treatment for renal dialysis and renal transplants which are crucial for maintaining your health.

## Oncology Risk Management Programme

All members diagnosed with cancer need to register on the programme to access oncology benefits. Your treating oncologist will provide a detailed treatment plan which will be assessed and authorised according to the programme's clinical protocols.



## YourLife Programme (HIV management)

The YourLife Programme assists registered members who are at risk of being HIV positive or have been diagnosed as a person living with HIV. All correspondence with the programme is **100% confidential**.

## Palliative Care Programme

Palliative care is specialised medical care for people living with serious conditions, focussed on providing relief and comfort from the symptoms and stress of their condition(s). The programme aims to provide holistic care and support to members, their families and caregivers when faced with terminal or life-threatening illnesses.

## Maternity Programme

The Maternity Programme offers pregnant members additional benefits during their pregnancy and in the first few weeks after the birth of their baby/ies. The programme is managed by qualified midwives who are equipped with knowledge of birth, antenatal care and caring for a newborn baby. Registration on the programme is recommended during the first trimester of pregnancy.



## Belly Babies online support

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

By registering on [www.bellybabies.co.za](http://www.bellybabies.co.za), you will have access to the following:

- an online antenatal course consisting of a comprehensive collection of videos, presented by various experts within the maternity field;
- an online face-to-face consultation with a highly qualified lactation (breastfeeding) specialist, to help you and your baby establish and maintain a happy breastfeeding routine. Book your personal consultation through the Belly Babies online platform; and
- a follow-up online face-to-face consultation with a lactation specialist, if needed.

# MANAGED HEALTHCARE PROGRAMMES (CONTINUED)

## Medicine Risk Management (MRM) Programme

The MRM department, which includes registered pharmacists and clinicians, uses set guidelines and protocols to assess each application for 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.

### Chronic medication

Chronic medication is taken continuously for a period of three months or longer for chronic conditions that are usually life threatening. To ensure that medication is paid from your chronic medication benefit rather than your MSA, you must contact the Medicine Risk Management (MRM) department to register your medication. 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.

By following the telephonic process, you may 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 005 037** (option 5), 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. You are entitled to one submission of this type of medication (which will usually have been directed to the chronic medication benefit) to be claimed from your MSA. If you attempt to claim this type of medication from your MSA for a second time, the claim will be rejected.

**Get your chronic medication from our preferred pharmacies listed below:**

<b>Clicks Pharmacy</b>	Please visit or contact your nearest branch to make enquiries.
<b>Dis-Chem Pharmacy</b>	Please visit or contact your nearest branch to make enquiries.
<b>Medipost Pharmacy</b>	Telephone <b>012 426 4000</b> Email <b>info@medipost.co.za</b> Website <b>www.medipost.co.za</b>
<b>Schuin-Villa Pharmacy</b>	322 Cape Road, Newton Park, Gqeberha/Port Elizabeth 6045 Eastern Cape Telephone <b>041 364 3566</b>
<b>Strubenvale Pharmacy</b>	Corner of Ermelo and Largo Road, Strubenvale, Springs 1559 Gauteng Telephone <b>011 362 5597</b>

Alternatively, visit [www.pggmeds.co.za](http://www.pggmeds.co.za) (Healthcare Programmes > Medicine Risk Management) to find a pharmacy registered on the Scheme's pharmacy network list.

### Chronic disease list (CDL)

The CDL includes 26 PMB 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 through network healthcare providers.

1. Addison's disease
2. Asthma
3. Bipolar mood disorder
4. Bronchiectasis
5. Cardiac (heart) failure
6. Cardiomyopathy disease
7. Chronic obstructive pulmonary disease (COPD)
8. Chronic renal (kidney) disease
9. Coronary artery (heart) disease
10. Crohn's disease
11. Diabetes insipidus
12. Diabetes mellitus type 1 and 2
13. Dysrhythmias
14. Epilepsy
15. Glaucoma
16. Haemophilia
17. HIV
18. Hyperlipidaemia (high cholesterol)
19. Hypertension (high blood pressure)
20. Hypothyroidism (under-active thyroid)
21. Multiple sclerosis
22. Parkinson's disease
23. Rheumatoid arthritis
24. Schizophrenia
25. Systemic lupus erythematosus
26. Ulcerative colitis



## MANAGED HEALTHCARE PROGRAMMES (CONTINUED)

### Medicine Risk Management (MRM) Programme (continued)

#### Acute medication

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

**Please note:** Many of the Clicks and Dis-Chem pharmacies offer skip-the-line collection and/or courier services. Please ask for details at the pharmacy counter on your next visit.

#### Generic medication

Generic medication helps you save money. Did you know that it is not necessary for a pharmacist to consult your healthcare provider to make 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 original 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 while they recover their costs. Once 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.

#### Prescribed minimum benefit (PMB) list

The PMB medication list is primarily indicated for PMB CDL conditions and some additional 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 usually have been directed to the chronic medication benefit) to be claimed from your MSA. If you attempt to claim this type of medication from your MSA 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 005 037** (option 2).

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

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

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

- bone densitometry/dual-energy X-ray absorptiometry (DEXA) scans;
- cancer treatment;
- dentistry in hospital;
- dialysis;
- emergency services via Netcare 911;
- external medical appliances;
- mammograms;
- MRI, CT and Positron emission tomography (PET) scans;
- organ transplants;
- oxygen supply;
- private nursing and hospice;
- psychiatric hospitalisation;
- rehabilitation;
- stomatherapy; and
- surgical prostheses.

## Emergency admission

In the event of emergency hospitalisation, where you are unable to obtain pre-authorisation, the hospital may do so on your behalf, otherwise your next of kin must inform the Scheme on **0860 005 037** (option 2) 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.

**Please refer to the benefits table on page 22 for more information.**



# MOTOR VEHICLE ACCIDENTS (MVAs) AND INJURIES

Accidents and injuries **resulting from motor vehicle accidents (MVAs)** 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 (RAF). 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 005 037**.

# TIPS TO COMBAT HIGH HEALTHCARE COSTS

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

**The following suggestions may 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 and check that they appear on your claims statement.



# CLAIMS PROCEDURE

Please submit your claims by email to [claims@pggmeds.co.za](mailto:claims@pggmeds.co.za). Please include one claim per email to ensure that all claims are received.

Alternatively, you may submit claims by post directly to:

**PG Group Medical Scheme**  
**PO Box 2070**  
**Bellville**  
**7535**

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 invoices include:

- the Scheme's registered name – PG Group Medical Scheme;
- the principal member's name and the name of the patient treated (principal member or dependant) as registered and indicated on the membership certificate/card;
- the correct medical scheme membership number and reference number, if applicable;
- the treating healthcare provider's and/or healthcare facility's name and practice number; and
- proof of payment 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 Scheme name and your membership details.

## Payment of claims

In most cases, claims for healthcare services and medication will be paid directly to the healthcare providers. If you pay cash for treatment and/or medication from a healthcare provider, please submit your claim to the Scheme as indicated above. It remains your responsibility to settle the healthcare provider's account in full.

## Remember the ICD-10 codes

All healthcare providers are required, by law, to indicate ICD-10 diagnosis 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.

Therefore, it is important to confirm with your healthcare provider that they have 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 rejection codes 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 Benefits Committee.
- Cosmetic procedures, including treatment for obesity.
- Costs related to legal fees arising out of overdue medical accounts.
- Dangerous sport and activities, e.g. racing contest\*.
- Elective, non-medically justifiable treatment.
- Executive medical examinations.
- Holidays for recuperative purposes.
- Injuries arising out of riots, unrest, etc\*.
- Injury caused by alcohol or drug abuse\*.
- Insurance or physical fitness examinations.
- Laser refractive eye surgery.
- Medical costs in excess of defined limits\*.
- Medical costs that may be recovered from a third party.
- Participation in medical research/trials.
- Patent, proprietary medication and bandages, patent food preparations and domestic/biochemical remedies\*.
- Sunglasses.
- Fertility treatment and artificial insemination\*.
- Wilful, self-inflicted injury\*.

\* Subject to prescribed minimum benefits (PMBs)



# UNDERWRITING

Waiting periods and exclusions are categorised under the broader definition of underwriting and are measures prescribed by law, particularly the Medical Schemes Act 131 of 1998, which allow medical schemes to protect their financial wellbeing. All medical schemes may apply certain underwriting policies to new members. Risk underwriting refers to the risk factors of members, such as their average age, 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.

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 or 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 or interrupted 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 may 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 still apply.

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 supplied at a later stage.

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. This means that you and your dependants will enjoy cover immediately – waiting periods, exclusions and late-joiner penalties will not apply. Should your family status change, such as marriage, having a baby or adoption, **kindly ensure that your new dependant is registered on the Scheme within 30 days, to avoid underwriting being applied to their membership.**



# MEDICAL SAVINGS ACCOUNT (MSA)

You contribute a portion of your monthly contribution towards your 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 MSA balance for the following year. Being careful with your MSA funds will enable you to build up considerable medical savings 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 outstanding claims are paid first. If you join another medical scheme that has a medical savings option, your remaining funds will be transferred to your new medical scheme. With effect from 1 January 2018, the Scheme no longer pays interest on positive MSA balances.

**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 pay 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 may be used to cover:

- acute and over-the-counter (OTC) medication;
- audiology;
- chiropody and podiatry;
- chiropractors;
- clinical psychology (consultations for members registered for one of the CDL mental health conditions are subject to the member's authorised PMB treatment plan benefits);
- dentistry co-payments;
- dieticians;
- optometry co-payments;
- 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 work and other auxiliary services; and
- speech and occupational therapy.

## Note

Should you need to use your positive MSA balance to cover any medical shortfalls on any outstanding claims, please send a written request by email to [info@pggmeds.co.za](mailto:info@pggmeds.co.za) and we will process your request and assist you with your refund.



# PREFERRED PROVIDER NEGOTIATORS (PPN)

## Optical benefits

Preferred Provider Negotiators (PPN), South Africa's largest optometry network, provides members with enhanced optical benefits on behalf of the Scheme. PPN has agreements with more than 2 200 optometrists throughout South Africa.

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 795** 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.

Optical benefits in and out of network	
Frame and/or lens enhancements	<b>R1 795</b> for frames and/or lens enhancements per beneficiary at a PPN provider <b>OR</b> <b>R1 346</b> per beneficiary at a non-PPN provider every two years
One pair of clear Aquity® single-vision lenses; or	<b>R215</b> per lens
One pair of clear Aquity® bifocal lenses; or	<b>R460</b> per lens
One pair of base multifocal lenses	<b>R810</b> per lens
<b>OR</b>	
Contact lenses	<b>R2 370</b>
Contact lens re-examination (subject to the Scheme rules and may only be claimed in six-monthly intervals)	<b>R255 x 3</b>

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, artificial intelligence (AI) screening and either spectacles or contact lenses. These claims will be paid at 100% of the benefit limits.
- Ready-made readers: two pairs (in a two-year cycle) – **R150** per pair in lieu of spectacle lenses.

### Out-of-network benefits

- One consultation paid at **R400** for either spectacles or contact lenses.

**Please check the following with your optometrist to ensure that you optimise your optical benefit and reduce the risk of co-payments:**

1. Are you part of the PPN network?
2. Please prescribe within my available limits.
3. Kindly explain what my co-payments will be if I choose a higher costing frame and/or lens enhancements.

**Shortfalls will automatically be paid from your available positive MSA balance.**

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](http://www.ppn.co.za).

**Please submit optical claims to:**

Email [claims@ppn.co.za](mailto:claims@ppn.co.za)

Fax **041 586 4184**

Post **Preferred Provider Negotiators, PO Box 12450, Centrahil 6006**



**041 065 0650**



# DENTAL INFORMATION SYSTEMS (DENIS)

## Dental benefits

Dental Information Systems (DENIS), Africa's leading dental funder, manages your dental benefits on behalf of the Scheme. There is a predefined benefit per procedure, which is paid at the PG Group Dental Tariff (PDT), which is published and distributed by DENIS annually. Please visit [www.denis.co.za](http://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 benefit guide, which illustrates the benefits for 2025.

### 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 and are subject to managed care protocols.

### Conservative dentistry

- Two consultations/checkups per beneficiary per year (once every six months)
- Preventative care/oral hygiene includes two annual scale and polish treatments per beneficiary once every six months
- Fluoride treatment limited to beneficiaries from age five, and younger than 13
- X-rays – additional benefit may be considered for extra-oral X-rays where specialised dental treatment is required
- Fillings granted once per tooth every 720 days. A treatment plan and X-rays may be required for multiple fillings
- Extractions and root canal therapy
- Fissure sealants limited to beneficiaries younger than 16
- One set of upper and lower plastic dentures\* and associated laboratory costs per beneficiary in a four-year period
- Mouthguard clinical and associated laboratory costs

### Specialised dentistry

- Crowns and bridges\* – three crowns per family per year. Crowns granted once per tooth in a five-year period (treatment plan and X-rays may be requested)
- Two partial chrome cobalt frame dentures\* (upper and lower) per beneficiary in a five-year period
- Orthodontics (fixed braces)\* – only one family member may commence orthodontic treatment in a calendar year
- Two dental implants\* per beneficiary in a five-year period
- Surgery in dental chair

### Hospitalisation, general anaesthesia and sedation

- General anaesthesia in hospital\* is available for children under the age of five for extensive dental treatment, and for the removal of impacted teeth
- Sedation for dental anxiety
- Inhalation sedation in dental rooms
- Moderate/deep sedation in dental rooms\* limited to extensive dental treatment

\* Subject to pre-authorisation

**Shortfalls will automatically be paid from your available positive MSA balance.**

For more information and details of your dental benefits and exclusions, please refer to the DENIS dental benefit information guide, which is available on the Scheme's website at [www.pggmeds.co.za](http://www.pggmeds.co.za) (Home and Publications pages).

### Please submit dental claims to:

Email [claims@denis.co.za](mailto:claims@denis.co.za)  
Post DENIS Claims Department, Private Bag X1, Century City 7446

### Email addresses

Enquiries  
Claims  
Crowns and bridges  
Hospital authorisations and moderate deep sedation for dental treatment  
Orthodontic treatment/dental implants authorisation  
Periodontal treatment programme  
Dentures

[pgenq@denis.co.za](mailto:pgenq@denis.co.za)  
[claims@denis.co.za](mailto:claims@denis.co.za)  
[crowns@denis.co.za](mailto:crowns@denis.co.za)  
[hospitalenq@denis.co.za](mailto:hospitalenq@denis.co.za)  
  
[ortho@denis.co.za](mailto:ortho@denis.co.za)  
[perio@denis.co.za](mailto:perio@denis.co.za)  
[customercare@denis.co.za](mailto:customercare@denis.co.za)

**denis**

0860 104 939



# WELLNESS BENEFITS

Where a particular test is driven by an age indicator in the wellness benefits, the same protocol will apply when that test is part of the general physical examination.

Benefit	ICD-10 code(s)	Tariff code(s)	NAPPI code(s)	2025 limits
<b>Vaccinations</b>				
Baby immunisation programme	-	-	-	Covered for the first six years of a child's life as required by the Department of Health, subject to the baby and childhood vaccine formulary
Flu vaccinations	Z25.1	-	-	Once a year for all beneficiaries
Tetanus diphtheria (Td) booster	Z23.5	-	-	As needed for all beneficiaries
Pneumococcal vaccinations	Z23.8	-	-	As needed for beneficiaries 60 years and older, and high-risk beneficiaries
<b>Early detection and screening</b>				
General physical examination (in GP's rooms)	Z0.00	0190 0191 0192 4188	-	One medical examination every five years for adults 21 to 29 years old  One medical examination every three years for adults 30 to 59 years old  One medical examination every two years for adults 60 to 69 years old  One medical examination every year for adults 70 years and older
Cholesterol test (Pathologist)	Z13.6	4025 4026 4147	-	Once a year for all adult beneficiaries
Pap smear consultation (GP/Gynaecologist)	Z01.4	0190 0191 0192 4566	-	Once a year for females 15 years and older
Pap smear test				
DEXA bone density scan (Radiologist)	Z01.6	50120	-	Once every three years for beneficiaries 50 years and older
OR				
DEXA bone density scan (GP/Gynaecologist)		3604		Once every three years for beneficiaries 50 years and older
Colorectal screening test (Pathologist)	-	4352	-	Once a year for beneficiaries 40 years and older
Full blood count (FBC)	-	3755	-	All adult beneficiaries, as needed
Erythrocyte sedimentation rate (ESR)	-	3743	-	All adult beneficiaries, as needed
Urea, creatinine and electrolytes	-	4032 4171	-	All adult beneficiaries, as needed
Uric acid	-	4155	-	All adult beneficiaries, as needed
Gamma-glutamyl transferase (GGT)	-	4134	-	All adult beneficiaries, as needed
Fasting glucose	-	4057	-	All adult beneficiaries, as needed
Chest X-ray: lung cancer detection	Z01.6	30100 30110	-	Once a year for all adult beneficiaries: <ul style="list-style-type: none"> <li>- between the age of 55 to 74</li> <li>- who are current/former smokers (having quit within the preceding 15 years)</li> <li>- with at least a 30-pack-day smoking history and with no history of lung cancer</li> </ul>

## WELLNESS BENEFITS (CONTINUED)

Benefit	ICD-10 code(s)	Tariff code(s)	NAPPI code(s)	2025 limits
<b>Early detection and screening (continued)</b>				
<b>Prostate-specific antigen (PSA) test</b>	-	4519 4524	-	Once every three years for male beneficiaries from the age of 40 to 49  Once a year for male beneficiaries from the age of 50
<b>Human papillomavirus (HPV) vaccine</b>	-	-	00710020001 00710249001 00710249002 03006049001	One treatment (two doses) in a lifetime for male and female beneficiaries  Male beneficiaries aged 9 to 18  Female beneficiaries aged 9 to 26  A third dose may be considered for high-risk women up to the age of 45, based on motivation from their treating doctor
<b>Health assessments from a nurse/pharmacy clinic</b> Blood pressure, finger-prick cholesterol, blood glucose (sugar) tests and height, weight and waist circumference or body mass index (BMI)	Z00.0	88001	00711326001	Once a year for all adult beneficiaries
<b>Maternity benefits</b>				
<b>Subject to compulsory registration on the Maternity Programme (0860 005 037 – option 2).</b>				
<b>Antenatal visits</b> (GP/Gynaecologist)	-	0190 0191 0192	-	12 visits
<b>OR</b>				
<b>Antenatal visits</b> (Midwives)	-	88420	-	12 visits
<b>Urine test</b> (GP/Gynaecologist)	-	4188	-	Included in the 12 antenatal visits
<b>Scans – one before the 24th week and one after the 24th week</b> (Radiologist)	-	43250 43260 43270 43273 43277	-	Two scans
<b>OR</b>				
<b>Scans – one before the 24th week and one after the 24th week</b> (GP/Gynaecologist)	-	3615 3617 5106 5107 5108	-	Two scans
<b>Paediatrician visits</b>	-	0190 0191 0192	-	Two visits in the first year (12 months) for baby/ies registered on the programme



# ADDITIONAL PREVENTATIVE SCREENING TESTS COVERED AT NO COST TO YOU

Test	ICD-10 code(s)	Tariff code(s)	2025 limits
<b>Cholesterol screening</b> (Pathologist)	-	4027	One every two years for adult beneficiaries
<b>Mammogram</b> (Radiologist)	-	34100 34101	One every two years for females 40 years and older  Once a year for females with risk factors for breast cancer and where clinically indicated family history exists
<b>Mammogram</b> (GP/Gynaecologist)	-	3605	
<b>Glaucoma screening</b>	-	3014	One screening every two years for adults 40 years and older
<b>HIV test</b> (Pathologist)	-	3932	Once a year for beneficiaries 15 years and older



# 2025 BENEFITS

**Overall annual limit (OAL): R400 000 per beneficiary**

All individual benefit limits are subject to the OAL.

## THE SCHEME HAS INTRODUCED THE FOLLOWING NEW BENEFITS FOR ITS MEMBERS IN 2025:

- A continuous glucose monitoring devices and consumables benefit of up to R25 000 per beneficiary per year.
- A standalone benefit for speciality chronic (biological) medication of up to R100 000 per beneficiary per year, subject to a 20% co-payment. This benefit aims to facilitate access for beneficiaries with rare or severe medical conditions who require high-cost specialised treatments.
- A hearing aid maintenance benefit of up to R1 500 per beneficiary per year.
- Separate limits for external medical appliances to ensure sufficient coverage for its members.
- Momentum Hello Doctor is a mobile-based service that gives you access to a doctor through the 24/7 advice line. In addition, the Scheme has now approved the Hello Doctor virtual consultation to provide a platform for its members dealing with acute conditions. This service is staffed by contracted general practitioners (GPs) and is accessible around the clock throughout the year. The offerings include medical advice, formal diagnoses of certain medical conditions, referrals for diagnostic tests and the issuing of prescriptions and sick notes. The cost per consultation is R278.

## ABBREVIATIONS:

CDL Chronic disease list

MSA Medical savings account

PMB Prescribed minimum benefit

CPAP Continuous positive airway pressure

MRM Medicine Risk Management

SEP Single exit price

GP General practitioner

OAL Overall annual limit

TTO To-take-out

In-hospital treatment	Limits	Paid from
<b>PRE-AUTHORISATION IS REQUIRED FOR ALL IN-HOSPITAL TREATMENT</b>		
In an emergency hospitalisation, where you are unable to obtain pre-authorisation, the hospital may do so on your behalf, alternatively your next of kin must inform the Scheme on <b>0860 005 037</b> (option 2) 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.		
Failure to obtain pre-authorisation will result in you being liable for the full cost of hospitalisation and related expenses. Benefits will be provided according to the Scheme rules, benefits, clinical protocols and limits.		
<b>Hospitalisation*</b> Ward and theatre fees, intensive care unit (ICU) and high-care wards, medication, material, equipment, transfusions and transfer of blood. Excludes dental implants, private ward, refractive surgery, psychiatric treatment, organ transplants (see organ transplants benefit) and TTO (see acute medication benefit).	100% of Scheme rate	In-hospital benefits  Subject to OAL
<b>Motor vehicle accidents (MVAs) and injuries*</b> Includes injuries involving third parties, subject to accident/injury report and legal undertaking from member.	100% of Scheme rate	In-hospital benefits  Subject to OAL
<b>Maternity benefits (confinements in hospital)*</b> Deliveries in private and State hospitals (includes complications for mother and baby/ies). Benefit includes all costs relating to hospitalisation.	100% of Scheme rate	In-hospital benefits  Subject to OAL
<b>Maternity benefits (home deliveries by a registered nurse/midwife and antenatal visits)*</b>	100% of Scheme rate	Subject to OAL
<b>In-hospital treatment from medical practitioners (consultations and services in hospital)*</b> GPs, specialists, technicians and physiotherapists. Excluding costs for maxillofacial and oral surgery, except for oncology cases.	100% of Scheme rate	In-hospital benefits  Subject to OAL
<b>Ambulance services (emergency services)*</b> Road ambulances, emergency services, general advice line, air evacuation and transportation. Contact Netcare 911 on <b>082 911</b> .	100% of Scheme rate  <b>R3 748</b> per family if Netcare 911 is not used	Subject to OAL
<b>Internal prostheses and appliances*</b> Including pacemakers, electronic devices, coronary stents and joint replacements.	100% of agreed cost  <b>R60 570</b> per family per year	In-hospital benefits  Subject to OAL

\* Subject to pre-authorisation

## 2025 BENEFITS (CONTINUED)

In-hospital treatment (continued)	Limits	Paid from
<b>Renal disorders (kidney and home dialysis)*</b> Including related medication therapy (through approved healthcare providers only). All cases subject to full investigation.	100% of Scheme rate  <b>R267 079</b> per family per year	Subject to OAL  Subject to registration on the Renal Care Management Programme
<b>Organ transplants*</b> Including organ harvesting and immunosuppressive medication. Subject to transplant motivation.	100% of Scheme rate	Subject to OAL thereafter only PMBs
<b>Mental health*</b> Hospital admissions and all related services at approved facilities for mental health conditions including anorexia and bulimia nervosa, treatment for alcohol and chemical substance abuse.	100% of Scheme rate  <b>R56 538</b> per family per year  21 days per beneficiary	In-hospital benefits  Subject to OAL
Out-of-hospital treatment received in rooms	Limits	Paid from
<b>Consultative services (specialist treatment)</b> Specialist conditions and treatment out of hospital by anaesthetists, neurosurgeons, general or other surgeons, orthopaedic specialists, ear, nose and throat (ENT) doctor/otorhinolaryngologists, radiotherapists, thoracic surgeons, urologists and cardiologists and nursing practitioners.	100% of Scheme rate  M: <b>R4 785</b> M+1: <b>R7 821</b> M+2: <b>R9 580</b> M+3: <b>R10 292</b>	Out-of-hospital benefits  Subject to OAL
<b>General practitioners and certain specialists</b> Outpatients, out-of-hospital consultations, treatment and procedures in doctors' rooms, includes dermatologists, gynaecologists, ophthalmologists, paediatricians, neurologists, plastic surgeons and medical supplies (needles, syringes and sterile trays).	100% of Scheme rate	Subject to available MSA
<b>Diagnostic radiology and pathology*</b> Including materials. Referring healthcare provider's practice number must appear on all claims. Pre-authorisation required for MRI, bone densitometry/dual-energy X-ray absorptiometry (DEXA), mammograms and computed tomography (CT/CAT) scans.  Out-of-hospital radiology and pathology benefits	100% of Scheme rate  M: <b>R18 720</b> M+1: <b>R30 960</b> M+2: <b>R34 990</b> M+3: <b>R43 796</b>  80% of Scheme rate	Out-of-hospital benefits  Subject to OAL  20% from MSA
<b>Note!</b> Authorised oncology-related scans are subject to the oncology benefit, and authorised non-oncology related scans are subject to the diagnostic radiology benefit.		
<b>Oncology*</b> Chemotherapy, radiotherapy, intravenous medication and materials. Subject to the approval of a comprehensive treatment plan.	100% of Scheme rate	Subject to registration on the Oncology Risk Management Programme  Subject to OAL
<b>Prescribed chronic medication*</b> Medication prescribed or dispensed to patients registered on the Scheme's MRM Programme. Unlimited cover for CDL/PMB chronic medication.	100% of SEP and dispensing fee  Limits applicable to non-PMB chronic medication  M: <b>R27 903</b> M+1: <b>R46 487</b> M+2: <b>R55 795</b> M+3: <b>R65 218</b>  <b>R25 000</b> per beneficiary per year  <b>R100 000</b> per beneficiary per year, subject to a 20% co-payment	Subject to registration on the MRM Programme  Subject to OAL
<b>NEW BENEFITS</b>		
Continuous glucose monitoring devices and consumables*		
Speciality chronic (biological) medication for members with rare or severe medical conditions that require high-cost specialised treatments*		Subject to OAL
<b>HIV*</b> Antiretroviral therapy (ART)	100% of Scheme rate  Unlimited	Subject to registration on the YourLife Programme

\* Subject to pre-authorisation

## 2025 BENEFITS (CONTINUED)

Out-of-hospital treatment received in rooms (continued)	Limits	Paid from
<b>Acute medication</b> All medication, including TTO (maximum seven days' supply), except those obtained through the MRM Programme. Clinically and pharmacy-dispensed vaccinations.	100% of SEP and dispensing fee  Pharmacy-advised therapy (PAT) and over-the-counter (OTC) medication dispensed by pharmacists limited to <b>R325</b> per prescription	Subject to available MSA
<b>Physiotherapy/Biokinetics</b>	100% of Scheme rate	Subject to available MSA
<b>External medical appliances*</b>  <b>NEW BENEFITS</b>  Wheelchairs  Home oxygen  Stoma products  CPAP machine  CPAP machine consumables  Orthopaedic appliances  Other medical appliances (e.g. blood pressure monitors, glucometers, nebulisers, etc.)	100% of Scheme rate  <b>R8 000</b> per beneficiary once every four years  <b>R15 000</b> per beneficiary per year  <b>R15 000</b> per beneficiary per year  <b>R12 000</b> per beneficiary every four years  <b>R3 000</b> per beneficiary per year  <b>R4 000</b> per beneficiary per year  <b>R1 500</b> per beneficiary every four years	Out-of-hospital benefits  Subject to OAL
<b>Hearing aids*</b>  <b>NEW BENEFIT</b>  Hearing aid maintenance benefit to prolong the lifespan of hearing aid devices	100% of Scheme rate  <b>R20 000</b> per ear per beneficiary every four years  <b>R1 500</b> per beneficiary per year	Out-of-hospital benefits  Subject to OAL
Community care	Limits	Paid from
<b>Private nursing and hospices – in-patient services at an approved healthcare facility*</b> In lieu of hospitalisation only. Nursing services and sub-acute facilities. Subject to submission of healthcare provider's comprehensive treatment plan and Scheme approval. <b>Frail care services are not included.</b>	100% of Scheme rate	Subject to OAL
<b>Rehabilitation (physical rehabilitation)*</b> Subject to submission and approval of a treatment plan. This benefit is only applicable to in-hospital approved rehabilitation according to clinical protocols.	100% of Scheme rate  27 days per family per year (except for PMBs)	Subject to OAL
<b>Rehabilitation (psychiatric/substance abuse)*</b> To treat abuse or dependence on psycho-active substances, including alcohol. This benefit is only applicable to in-hospital approved rehabilitation according to clinical protocols.	100% of Scheme rate  Benefit of 21 days per beneficiary per year in a South African National Council on Alcoholism (SANCA)-approved rehabilitation facility	Subject to OAL
<b>Blood transfusion and technologists*</b> Bags, pouches and flanges.	100% of Scheme rate	Subject to OAL
<b>Alternative medical services</b> All services from homeopaths and chiropractors, chiropodists, naturopaths and osteopaths.	100% of Scheme rate	Subject to available MSA
<b>Other medical services</b> Speech and occupational therapy, audiology, podiatry, dieticians, social workers, orthoptics, clinical psychologists and educational, remedial and marriage counselling.	100% of Scheme rate	Subject to available MSA

\* Subject to pre-authorisation

# 2025 CONTRIBUTIONS

The contribution amounts for 2024 will apply for the first three months of 2025, i.e. 1 January to 31 March 2025; thereafter, new contribution amounts will be charged from 1 April to 31 December 2025. Please remember that gross income bands will also be adjusted from 1 April 2025.

## Total consolidated contribution table

Current contribution amounts continuing from 1 January 2025 to 31 March 2025

Gross income	Principal member	Adult dependant	Child dependant
R0 - R5 500	R2 700	R2 700	R810
R5 501 - R9 750	R3 000	R3 000	R810
R9 751 - R11 250	R3 150	R3 150	R850
R11 251 - R13 600	R3 300	R3 300	R890
R13 601 - R15 500	R3 550	R3 550	R960
R15 501 - R18 500	R3 750	R3 750	R1 010
R18 501 - R23 500	R4 050	R4 050	R1 060
R23 501 - R34 000	R4 350	R4 350	R1 100
R34 001 +	R4 450	R4 450	R1 100

Increased contribution amounts effective from 1 April 2025 to 31 December 2025

Gross income	Principal member	Adult dependant	Child dependant
R0 - R5 780	R2 830	R2 830	R864
R5 781 - R10 250	R3 142	R3 142	R864
R10 251 - R11 850	R3 300	R3 300	R908
R11 851 - R14 250	R3 463	R3 463	R952
R14 251 - R16 300	R3 700	R3 700	R1 018
R16 301 - R19 450	R3 935	R3 935	R1 082
R19 451 - R24 700	R4 225	R4 225	R1 145
R24 701 - R35 750	R4 540	R4 540	R1 195
R35 751 +	R4 665	R4 665	R1 195

## Monthly member medical savings account (MSA) contribution table

Current contribution amounts continuing from 1 January 2025 to 31 March 2025

Gross income	Principal member	Adult dependant	Child dependant
R0 - R5 500	R541	R541	R162
R5 501 - R9 750	R601	R601	R162
R9 751 - R11 250	R631	R631	R170
R11 251 - R13 600	R661	R661	R178
R13 601 - R15 500	R711	R711	R192
R15 501 - R18 500	R751	R751	R202
R18 501 - R23 500	R811	R811	R212
R23 501 - R34 000	R871	R871	R220
R34 001 +	R891	R891	R220

Increased contribution amounts effective from 1 April 2025 to 31 December 2025

Gross income	Principal member	Adult dependant	Child dependant
R0 - R5 780	R565	R565	R172
R5 781 - R10 250	R627	R627	R172
R10 251 - R11 850	R659	R659	R181
R11 851 - R14 250	R691	R691	R190
R14 251 - R16 300	R739	R739	R203
R16 301 - R19 450	R786	R786	R216
R19 451 - R24 700	R843	R843	R229
R24 701 - R35 750	R906	R906	R239
R35 751 +	R931	R931	R239

# COMPLAINTS PROCESS

Complaints are inevitable in every industry; however we view complaints as an opportunity to enhance our internal processes to create a better member experience. If you are unhappy with any aspect of your membership of the PG Group Medical Scheme, we encourage you to contact the Scheme or our administrator, Momentum Health. We will deal with your complaints as efficiently and effectively as possible and make sure you are aware of the proper process to follow.

Call **0860 005 037** or email [info@pggmeds.co.za](mailto:info@pggmeds.co.za), so that we may address your concerns.

Should you feel that your concerns are not being addressed or your complaint has not been resolved to your satisfaction, you may contact the Scheme's Principal Officer directly to raise your concerns.

## The contact details are:

### Mrs Chontal Dunstan

Telephone **011 417 5800**  
Email [cdunstan@pg.co.za](mailto:cdunstan@pg.co.za)  
Post **PG Group Head Office**  
**18 Skeen Boulevard**  
**Bedfordview**  
**2007**



**In the unfortunate event that you have exhausted the above options, and your complaint was not resolved to your satisfaction by the Scheme or our administrator, you may report it to the Council for Medical Schemes (CMS).**










The **CMS** is a statutory body established by the Medical Schemes Act 131 of 1998 to provide regulatory supervision of private healthcare financing through medical schemes in South Africa. They also assist with handling complaints from medical scheme members that may not have been resolved with their respective medical schemes.

## CMS contact details

Customer care telephone **0861 123 CMS (0861 123 267)**  
Enquiries email address [information@medicalschemes.co.za](mailto:information@medicalschemes.co.za)  
Complaints email address [complaints@medicalschemes.co.za](mailto:complaints@medicalschemes.co.za)  
Physical address **Block A, Eco Glades**  
**2 Office Park**  
**420 Witch-Hazel Avenue**  
**Eco-Park Estate**  
**Centurion**  
**0157**



# IMPORTANT CONTACT DETAILS

<b>Customer care</b>	<i>For any Scheme enquiries</i> <b>Monday to Friday, 08:00 to 16:30</b>	
	Telephone	<b>0860 005 037</b>
	WhatsApp	<b>0860 005 037</b>
	Email	<b>info@pggmeds.co.za</b>
	<b>Press</b>	
	<b>1</b> for benefits confirmation and claims enquiries	
	<b>2</b> for hospital admissions, pre-authorisations, maternity and oncology	
	<b>3</b> for dental benefits and authorisation	
	<b>4</b> for HIV-related queries	
	<b>5</b> for chronic medication	
<b>Physical address</b>	Parc du Cap, 7 Mispel Road, Bellville 7530	
<b>Postal address</b>	<i>For claims submission, administration and correspondence</i> PG Group Medical Scheme, PO Box 2070, Bellville 7535	
<b>Scheme website</b>	<b>www.pggmeds.co.za</b>	
<b>Membership queries</b>	Email	<b>membership@pggmeds.co.za</b>
<b>Claims submission</b>	Email	<b>claims@pggmeds.co.za</b>
<b>Fraud hotline</b>	Telephone	<b>0800 000 436</b>
	Email	<b>PGGmeds@tip-offs.com</b>
<b>Chronic medication registration and other medication-related queries</b>	<i>Medicine Risk Management (MRM) Programme</i>	
	Email	<b>chronic@pggmeds.co.za</b>
<b>Renal Care Management Programme</b>	<i>Renal/kidney failure and dialysis management</i>	
	Email	<b>renalcare@pggmeds.co.za</b>
<b>Palliative Care Programme</b>	<i>Palliative care and quality of life for serious illness</i>	
	Email	<b>palliativecare@pggmeds.co.za</b>
<b>YourLife Programme</b>	<i>HIV management programme</i>	
	Email	<b>yourlife@pggmeds.co.za</b>
<b>Netcare 911</b>	<i>Emergency assistance and ambulance service</i>	
	Emergencies/Health-on-Line	<b>082 911</b>
	Telephone	<b>0860 638 2273</b>
	Email	<b>customerservice@netcare.co.za</b>
	Website	<b>www.netcare911.co.za</b>
<b>Preferred Provider Negotiators (PPN)</b>	<i>Optical benefits</i>	
	Telephone	<b>041 065 0650</b>
	Fax	<b>041 586 4184</b>
	Email	<b>info@ppn.co.za/claims@ppn.co.za</b>
	Website	<b>www.ppn.co.za</b>
<b>Dental Information Systems (DENIS)</b>	<i>Dental benefits</i>	
	Telephone	<b>0860 104 939</b>
	Email	<b>pgenq@denis.co.za/claims@denis.co.za</b>
	Website	<b>www.denis.co.za</b>
<b>Medipost Pharmacy</b>	<i>Courier pharmacy for chronic medication</i>	
	Telephone	<b>012 426 4000</b>
	Email	<b>info@medipost.co.za</b>
	Website	<b>www.medipost.co.za</b>
<b>Momentum Hello Doctor</b>	<i>Expert health advice from qualified South African medical doctors</i>	
	Dial *120*1019# for a call back from a doctor, or download the app	
		
<b>Momentum Multiply</b>	<i>Lifestyle and wellness rewards programme</i>	
	Telephone	<b>0861 886 600</b>
	Email	<b>multiply@momentum.co.za</b>
	Website	<b>www.multiply.co.za</b>



## PROTECTION OF PERSONAL INFORMATION

PG Group Medical Scheme and the administrator, Momentum Health (Pty) Ltd, will maintain the confidentiality of your personal information and comply with the Protection of Personal Information Act 4 of 2013 (POPIA) and all existing data protection legislation, when collecting, processing and storing your personal information for the purposes of managing your membership of the Scheme and in accordance with the Medical Schemes Act 131 of 1998.

**The content of this publication is the intellectual property of PG Group Medical Scheme and Momentum Health (Pty) Ltd, the administrator, and any reproduction of this publication is prohibited unless written consent is obtained.**

*This member guide is intended as a general outline and contains a brief summary of benefits available to PG Group Medical Scheme members. Although every precaution was taken and to ensure the accuracy of information contained in this guide, in the event of a dispute, the official rules of the Scheme will always prevail.*



0860 005 037  
[www.pggmeds.co.za](http://www.pggmeds.co.za)