PG GROUP
MEDICAL SCHEME

Member Guide 2016

Contents

PG GROUP
MEDICAL SCHEME

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

The Scheme continues to be well managed and it it 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 provide 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.

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

Members are required to provide the Scheme with all the information regarding any treatment, care and diagnosis received in the 12 months preceding the application.

It is essential that members familiarise themselves with the Scheme Rules, thereby ensuring they understand their rights, responsibilities and benefit entitlement.

Members are also required to continuously update their status of beneficiaries with the Scheme. For example, when a child or any other dependant is no longer eligible to be a dependant, the member has to notify the Scheme to remove them as a dependant. Members should be familiar with the Scheme's membership eligibility provisions, since we have restricted Scheme membership. Remember that a member or dependant may only belong to one medical scheme at a given time.

Retirement

The Medical Schemes Act and the Rules of the Scheme make provision for members to retain Scheme membership in the event of their services being terminated from the company on account of normal retirement, early retirement or retirement due to ill-health or other disability. This is subject to membership of the Scheme for a continuous period of not less than five years. Alternatively, continuous membership of another medical scheme prior to admission to PG Group Medical Scheme, where the break was not greater than three months, shall be recognised in calculating the five-year period. You will, however, become responsible for funding such membership in full at that time. Further details and conditions applicable are obtainable from your Human Resources Department.

Scheme Rules

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

How do you Join?

If you have just joined the PG Group, your employer will issue you with an application for membership form. Once you have completed the form, return it to your Human Resources Department to advise the Scheme. Remember to include all your dependants on this application form.

Proof of Membership

A membership card will be issued to you reflecting your membership number, 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 membership. Fraudulent use of cards leads directly to increased costs for all members.

Remember

Please complete the appropriate form and send it to your Human Resources Department to advise the Scheme of 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; and
- a change to your postal address.

Please advise the Scheme promptly about any changes, as a delay may affect the efficient settlement of your claims.

Who can you Register as a Dependant?

You can register your spouse or partner and dependant 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 and the member had contributed to the Scheme for a period of five consecutive years.

Glossary

Acute Medication
Medication that a doctor normally prescribes to alleviate the symptoms for an acute illness or condition, for example antibiotics or pain killers for headaches. Vaccinations that are clinically indicated and pharmacy dispensed are covered under this benefit.

Adult Dependant
A dependant who is 21 years and older.

Agreed Tariff
Our Scheme agreement with preferred providers, such as doctors and/or hospitals, where specific tariffs have been negotiated.

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

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

Benefits
The amount payable for medical services provided to members for themselves or their dependants in respect of the Rules.

Benefit Limits
The maximum treatment/amount payable for a specific benefit.

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 yet have generic equivalents.

Capitated Services
Clinical and/or administrative services provided by preferred providers. These services are paid on a per member per month basis and delivered up to limits specified in contracts with the preferred provider concerned.

Chronic Disease List (CDL)
The CDL consists of 25 chronic conditions covered by the Scheme in terms of the Regulations governing all medical schemes.

Chronic Diseases
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 should cover under 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've received medical treatment, you or the service provider (the doctor or hospital) submits a claim to the Scheme to request payment. If the provider charges Scheme Rates, the Scheme will pay the provider directly. Alternatively, you can pay the account from your own pocket and then claim the amount from the Scheme.

Clinical Algorithms and Protocols
A step-by-step problem-solving procedure especially established to diagnose and treat illnesses, which considers severity and treatment response.

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

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

Contribution
The fixed amount that you are paying monthly to be a member of the Scheme. You pay a fixed amount for each adult dependant and each minor dependant registered under your membership.

Cost
Represents the actual amount charged by a service provider.

Co-payment
This refers to a percentage of a claim for services rendered by a healthcare provider where fees exceed the Scheme Rate. The member is liable (i.e. out of pocket) to pay this amount. The aim is to place some cost burden on members and thereby discourage them from excessive use of healthcare services.

Creditable Coverage
Any period during which a late joiner was a member or dependant on a medical scheme.

CT and MRI Scans
Special X-rays taken of the inside 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.

Deductible
The amount that one must pay (upfront) from your own pocket to service providers.

Dental Benefits
These include a wide range of different dental treatments and procedures – please refer to Denis Dental Management (page 24).

Dependant
This includes a member's spouse or partner, who is not a registered member of another medical scheme, and a dependent child.

Glossary continued

Designated Service Provider (DSP) - Preferred Provider
A provider of service or a group of service 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.

Disease Management
It's a holistic approach that focuses on the member's condition, using all the cost elements involved. It can include counselling and education, behaviour modification, therapeutic guidelines, incentives, penalties and case management. The beneficiary usually has to co-operate with the programme in order to receive the benefit.

Emergency Medical Condition
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
Medical treatment and/or care not covered by the Scheme.

Formulary (Medication Formulary)
A defined preferred list of medication used to treat specific conditions. This is a list of cost-effective medication that guides the doctor 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.

Gap Cover
Members are offered a gap cover that will bridge the difference between the Scheme Rate and the amounts specialists charge members who are hospitalised for surgery or medical treatment and for certain procedures performed out of hospital.

General Waiting Period
The period in which a beneficiary is not entitled to claim any benefits. This is normally three months.

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 expires. As a result the generic medication is usually much cheaper.

HIV/AIDS
The Human Immunodeficiency Virus (HIV) is a retrovirus that breaks down the human body's immune system and can cause Acquired Immuno Deficiency Syndrome (AIDS). AIDS is a condition where the immune system begins to fail, which leads to life-threatening opportunistic infections.

International Classification of Disease (ICD-10) Codes
Healthcare providers need to include ICD-10 codes on all claims submitted to medical schemes as of 1 January 2005. Every medical condition and diagnosis has a specific code, called the ICD-10 code. 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 the services they rendered.

Late Joiner Penalty (LJP)
A penalty imposed on an applicant or adult dependant who, at the date of application for membership or admission as a dependant, as the case may be, is 35 years of age or older, but excludes any beneficiary who enjoyed coverage with one or more medical scheme as from a date preceding 1 April 2001, without a break in coverage exceeding three consecutive months since 1 April 2001.

Managed Healthcare
This is 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 guidelines and protocols the medical scheme has set out to manage the illness. For example, in the case of oncology treatment, managed healthcare would mean that you'd have to join the Oncology Management Programme. Your doctors and specialists, and the specialists from the Scheme, will work together to decide on the most cost-effective treatment programme. Managed healthcare may assist in the appropriate management of conditions that require chronic medication, including HIV.

Maximum Medical Aid Price (MMAP)
This is the maximum price that the Scheme will pay for the cost of medication, where a generic alternative for branded medication does exist. Only the cost of the generic equivalent is covered.

Medicine Exclusion List (MEL)
The Scheme excludes payment for certain medication from the acute or chronic benefit for various reasons, unless it is a PMB condition.

Medicine Price List (MPL)
This is a reference pricing system whereby a ceiling price has been allocated to a group of medication, which are similar in terms of composition, clinical efficacy, safety and quality.

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

Minor
A dependant who is younger than 21 years of age.

Network
This refers to an institution or an individual service 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 service provider in offering benefits. Members are often limited to using the suppliers (i.e. doctors, pharmacies, hospitals) registered with this network of providers. Refer to your benefit schedule for requirements applicable to you.

Glossary continued

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

Out-of-pocket Payment
Payment made by an individual member directly to a healthcare provider, where fees exceed the Scheme Rate.

Overall Annual Limit (OAL)
The overall maximum benefit that a member and registered dependants are entitled to according to the Scheme Rules. This is calculated annually to coincide with the financial year of the Scheme.

Over-the-counter (OTC) Drugs/Pharmacy Advised Therapy (PAT) Non-prescribed Medication
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
A medical savings account held by a member's medical scheme. A set amount is paid towards savings on a monthly basis. When you need day-to-day medical services or supplies you can pay these using your savings. The Scheme refers to it as a medical savings account (MSA).

Pre-authorisation
The process of informing a medical scheme of a procedure 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
A condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12-month period preceeding the date on which an application for membership was made.

Prescribed Minimum Benefit (PMB)
The benefit that consists of the provision of the diagnosis, treatment and care costs of the 270 listed conditions and emergency medical conditions.

Private Hospital
Unlike State hospitals, private hospital groups are run as businesses and cost significantly more. Although some State facilities are excellent, private hospitals usually offer better aftercare.

Professional Dispensing Fee
A legislated maximum fee that a pharmacist or dispensing doctor may charge for services rendered to dispense medication.

Pro-rated Benefits
Some of the Scheme benefits are given on a calendar year basis, which means members have an annual limit available. If you joined the Scheme on a date other than 1 January, your benefits are calculated pro rata. If you exceed your annual limit, you'll have to pay excess costs out of your own pocket.

Rejection Codes
A list of codes that normally reflects on the remittance advice and indicates the reason for payment discrepancies.

Related Account
Any account/claim related to an approved in-hospital admission, other than the hospital account.

Restricted Medical Scheme
A medical scheme that only offers membership to the employees of a specific company.

Risk
In some cases your monthly contributions to your medical scheme will be split into two portions – a risk portion and a savings portion. The risk portion reflects your contribution to benefits that are paid by the medical scheme and not from your savings component.

Risk Underwriting
Risk factors include the average age of members, the pensioner ratio as well as the number of chronic medication users within the group. Once this information has been established, the Scheme decides what underwriting will be applied to the group with regards to new applicants – please refer to Underwriting.

Scheme Rate/Tariff
The rate the Scheme determines for paying healthcare providers.

Single Exit Price (SEP)
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 Medicine 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 (doctors and specialists). It is a guideline for doctors in private practice regarding the fees they may charge for their services.

To-take-out (TTO) Medication
The medication taken home, but prescribed to the beneficiary whilst in hospital.

Underwriting
Depending on your previous medical scheme history, the Scheme can apply underwriting on your new membership. This means that, according to regulation, the Scheme is allowed to impose a three-month general waiting period and/or a 12-month waiting period on an existing condition. A late joiner penalty can 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 benefits for new members. No benefits are paid during this period, not even from the MSA (medical savings account), except for some procedures that are covered as a PMB in accordance with the Medical Schemes Act.

Value Added Products for 2016

Web-based Self-help Facility (Customer Online)

Visit **www.pggmeds.co.za**, click on "login" (included in the menu item list on the home page) and login using your membership number and Personal Identification Number (PIN). If you do not have a PIN, simply register for one by clicking on "Register" and using your membership number, a four-digit PIN of your choice and your ID number.

Membership

- Check and update telephone/cell phone numbers, and postal/residential addresses.

Statements

- View past monthly statements.

New Membership Card

- Apply for a new membership card.

Claims

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

Steps to Register

- Log onto **http://www.pggmedsonline.co.za**.
- Click on **Register**.
- Enter your membership number.
- Choose a four-digit numerical PIN.
- Validate your ID number and submit.

Alternatively, you may contact the Call Centre on **0860 00 50 37** to register.

NETCARE 082 911
24HR EMERGENCY MEDICAL ASSISTANCE

Netcare 911 Emergency Services

Netcare 911 at your service! Netcare 911 is South Africa's largest private emergency service, with highly skilled medical staff and a national network of emergency vehicles. Their doctor-based helicopter and fixed wing aeroplanes 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 you are a member of PG Group Medical Scheme.
- Do not put the phone down until the controller has disconnected.

Ambulance Authorisation Procedure

Contact Netcare 911 whenever possible. In the case of an inter-hospital transfer, when you are admitted to hospital, please inform the admitting hospital you are a Netcare 911 member and that any transfers must be done through **082 911**.

What to do with the Vehicle Window Sticker you Receive?
Netcare 911 encourages you to place the vehicle sticker, which you receive from the Scheme, on one of the side windows of your motor vehicle. This will alert any emergency service on the scene you are a member of 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 members 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.

Important Contact Details

Netcare 911 Head Office	:	**010 209 8911**
Emergencies	:	**082 911**
Health-on-Line	:	**082 911**
Website	:	**www.netcare911.co.za**
Email	:	**customer.service@netcare.co.za**

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

Value Added Products for 2016 continued

Admed

Gap Cover Policy

GUARDRISK TAILORED RISK SOLUTIONS

Guarding Yourself Against Medical Gaps and Shortfalls

Being a member of a medical scheme does not guarantee you full cover as you would expect, especially when you are hospitalised. Many healthcare providers charge considerably more than the Medical Scheme Tariff (MST) – some charge as much as five times higher than the MST. This creates a shortfall or gap between the MST and the actual cost incurred for the healthcare provider who treated you in hospital. As a member you would be personally liable for the difference in cost, which for specialists, surgeons and other healthcare providers could result in a sizeable amount. Admed offers you specially designed products that provide cover for the shortfall or gap in the event of hospitalisation involving surgery or medical treatment and for certain procedures performed out of hospital. A list of the defined out of hospital procedures are available in the policy document. You may only apply for gap cover if you are an active member of a medical scheme.

2016 Benefits Summary

- Benefit for shortfalls in healthcare provider costs* (shortfall cover).
- Benefit for co-payments/deductibles applied by your medical scheme for certain procedures.
- Benefit for co-payments levied by your medical scheme on oncology treatment programmes.
- Shortfalls for internal prosthesis costs.
- Lump sum benefit for first time cancer diagnosis.
- Lump sum benefit for accidental death and permanent total disability.
- Lump sum benefit for long-term hospitalisation.
- Fixed benefit for tooth repairs as a result of accidental injury.
- Hello Doctor benefit.

* Supreme Gap includes cover for shortfalls arising from prescribed minimum benefits.

Benefit Details

Benefits for Co-payments/Deductibles for Certain Procedures

Unlimited cover for in-hospital co-payments and deductibles applied by the medical scheme.

Benefit for Co-payments on Oncology Treatment Programmes

Where a co-payment is imposed by the medical scheme and the oncology benefit has been exceeded, Admed will cover the co-payment up to a maximum of 20% and limited to R250 000 per person per year. Policyholders are required to register with the medical scheme's oncology programme.

Benefit Shortfalls for Internal Prosthesis Costs

In-hospital procedures: Where an internal prosthesis was used and the medical scheme's limit has been exhausted, Admed will pay the shortfall up to a limit of R30 000 per policy per year.

Lump Sum Benefit for First Time Cancer Diagnosis

Where a person covered on the policy is diagnosed with cancer for the first time, Admed will pay a once-off benefit of R25 000. This amount is payable once in a lifetime per person covered on the policy.

Lump Sum Benefit for Accidental Death and Permanent Total Disability

Admed will pay a lump sum amount of R25 000 if a person covered on the policy dies or becomes permanently and completely disabled as a result of an accident. This benefit will be reduced if death relates to a minor.

Lump Sum Benefit for Long-term Hospitalisation

Where an insured person has been hospitalised for a period of 30 consecutive days or more, Admed will pay a lump sum of R25 000. This benefit will only be paid after the insured person has been discharged from hospital and is available only once per person covered on the policy per year.

Fixed Benefit for Tooth Repair Due to Accidental Injury
Where an insured person is required to undergo an emergency out-of-hospital dental procedure involving the repair of a tooth/teeth as a result of accidental injury to the mouth, Admed will pay a fixed benefit of R2 000 per tooth up to a maximum number of five teeth (R10 000) per policy per year.

2016 Rates (including VAT) = R112 per month (Admed Supreme Gap).

How to Claim

Claim forms can be obtained from your employer, our website at **www.guardrisk.co.za/en/products/admed** or by contacting our call centre on **0860 102 936**.

Claim forms should be submitted as soon as possible by:
Email : **admed@guardrisk.co.za**
Post : Admed Claims, PO Box 786015, Sandton 2146

TIC
TRAVEL INSURANCE CONSULTANTS
Travel Assured

International Medical Travel Insurance Cover (Leisure travel only)

Benefits and conditions:

- Ninety (90) days cover per trip worldwide – travel as often as needed.
- R5 000 000 per member for emergency medical cover.
- R100 000 cover for any pre-existing conditions if hospitalised.
- If hospitalised for more than 24 hours, no excess is payable.
- Evacuation from anywhere in the world to the nearest most appropriate facility and/or repatriation to country of residence, as deemed so by the assistance company MSO.
- Medical assistance 24 hours a day, seven days a week.
- Visit by a family member if the traveller is hospitalised (on approval by MSO's medical practitioner).
- Return home of children and/or travel companion if left stranded due to a member being hospitalised.
- Burial, cremation or return of mortal remains.

Remember

- All benefits are subject to terms and conditions of the policy wording. This will be issued at the time of request for a travel certificate. Cover is activated on declaration of travel to Travel Insurance Consultants (TIC).
- Members are advised to read the exclusions and the terms and conditions of the policy prior to starting their journey.
- Should members require emergency medical treatment overseas, the member needs to notify MSO immediately to ensure appropriate guarantees are sent to the provider. Failure to contact MSO when the treatment is received, will result in the member being liable for expenses over R10 000.
- Elective/planned procedures are not covered under this policy.
- Age limit is 80 years old, but an extension can be purchased at an additional cost for any persons aged 81 to 85 years old.

To obtain a valid travel certificate from TIC, please contact TIC on **+27 11 521 4000** or send them an email at **helpdesk@tic.co.za**.

To notify MSO of an incident/claim, please contact them on **+27 11 259 5003**.

Management Programmes

HIV YourLife Programme

Members and beneficiaries of the PG Group Medical Scheme have access to benefits for the treatment and management of HIV/AIDS. These benefits can be accessed by joining the HIV YourLife Programme.

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/her body and health. For people who are HIV positive, this is more important because their immune systems are unable 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, to inform us as soon as they are diagnosed. Mother-to-child transmission can be prevented.

How do I register?

Please phone our confidential line on **0860 10 97 93** 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 the doctor who will be responsible to treat your condition, 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?

Your benefits are focused on your total wellness and not just the virus. We have experienced that AIDS may not be the same in everybody and that each member has special needs. On registration, you are allocated a dedicated individual who will manage your condition within an allocated budget.

Benefits for Post-Exposure Treatment

Please contact us on **0860 10 97 93** or the after hours cell phone line **082 821 0994** 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 the possibility of having come into contact with the virus in order to meet the 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, teach you to live a positive and healthy life.

Contact Details

Tel : **0860 10 97 93**
Cell phone : 082 821 0994
Fax : 0861 888 301
Email : **pghiv@mhg.co.za**

HIV YourLife PROGRAMME

Oncology Management Programme

Registration on the Oncology Management Programme is compulsory for all members with cancer who want to access oncology benefits. Your treating oncologist must provide a detailed treatment plan with histology results, outlining all chemotherapy, radiotherapy, radiology, pathology, supporting drugs, pre-medication and anti-emetics, etc.

All applications are assessed in accordance with the treatment protocols and relevant benefits are provided. Please negotiate with your oncologist to charge you preferred tariffs. Please contact **0860 00 50 37**.

Renal Management Programme

A chronic renal application form needs to be completed by the treating specialist and submitted to the Scheme for registration on the Renal Management Programme. Benefits for renal dialysis and renal transplants are based on the details provided by the treating doctor and in accordance with the relevant treatment protocols. Members are advised to negotiate preferred tariffs with their doctors. Please contact **0860 00 50 37**.

Maternity Programme

The Maternity 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 member's confinement, postnatal care as well as any questions about their newborn baby. Registration is compulsory when the member is between eight and 20 weeks pregnant. Please contact **0860 00 50 37** during office hours.

Benefits of joining the Programme:

- Free access to all services offered by the Maternity 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 of 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.
- A pregnancy and birth book upon registration on the Programme.

Medication

Chronic Medication

Chronic medication is medication you need to take continuously for a period of three months or longer for chronic conditions that are usually recognised as life threatening. This medication needs to be approved by Medicine Risk Management (MRM). To ensure this medication is paid from your chronic medication benefit rather than your acute medication benefit or MSA, **you must register with MRM**. They are 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 staff, which include registered pharmacists and clinicians, use set guidelines and protocols to assess each application for chronic benefits and ensure that the drugs prescribed are appropriate, cost effective and prescribed in the correct therapeutic dosages. MRM guidelines are maintained in conjunction with medical specialists and local and international treatment protocols.

The process to apply for chronic medication or change your existing chronic authorisation has changed to a simple telephonic process. Should you require access to your chronic benefit or update your existing authorisation, please ask your doctor or pharmacist to contact the Scheme on **0860 00 50 37**, where after our team of pharmacists and assistants will **process your authorisation online**.

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

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

- Arcadia Pharmacy;
- Medipost; and
- Schuin-Villa Pharmacy.

Chronic Disease List (CDL)

The CDL list includes 25 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
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple Sclerosis
- Parkinson's Disease
- Rheumatoid Arthritis
- Schizophrenia
- Systemic Lupus Erythematosis
- Ulcerative Colitis

Acute Medication

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

Please note: Many of the Dis-Chem and Clicks Pharmacies do have 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 doctor prior to making a generic substitution? The decision to substitute medication now rests with the member, following the advice of the 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 trusted 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 medicine 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 MCCs standards. The MCC sets up 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.

Pre-authorisation for Hospitalisation

Members who are advised that they need to be hospitalised, are required to obtain prior approval for hospital procedures and treatment by contacting the Scheme on **0860 00 50 37**.

When members contact the Scheme for hospital authorisation, they are required to have certain information on hand consisting of:

- their membership number;
- the name and address of admitting doctor;
- the date of admission into hospital;
- the name of hospital or clinic;
- their medical condition;
- their diagnosis;
- the ICD-10/procedure codes;
- the type of procedure/operation (where applicable); and
- the expected length of stay.

Once the hospitalisation has been pre-approved, the member will be supplied with an authorisation number that is valid for 30 days from the date of issue. Members are required to provide their doctor and the relevant hospital or clinic with the authorisation number. **(The authorisation number confirms that benefits are available and guarantees the member's admission provided the member's contributions are up to date, however, it is not a guarantee of payment).**

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

Emergency Admission

In the event of emergency hospitalisation, where the member is unable to obtain pre-authorisation, the member's spouse or a family member is required to inform the Scheme on **0860 00 50 37** within 48 hours (two days) of admission. This will enable the Scheme to ensure the member receives quality care and 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: Netcare 911;
- external appliances;
- mammograms;
- MRI, CT and PET scans;
- organ transplants;
- oxygen supply;
- private nursing and hospice;
- psychiatric hospitalisation;
- rehabilitation;
- stomatherapy; and
- surgical prosthesis.

Please refer to the benefit schedule.

Accidents and Injuries (Including Motor Vehicle Accidents)

The Scheme pays your medical costs at 100% of the Scheme Rate for all motor vehicle accidents, even if the member is 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

A member who suffers even a minor injury will be required to submit a report/doctor's letter detailing the cause of the injury. Where the injury is severe, the member 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 could help reduce costs and curb high annual increases:

- Please ask for a copy of your account even if the doctor/pharmacist submits the account directly.
- Check all accounts carefully.
- Ensure that your doctor only prescribes the required amount of medication (not surplus medication).
- Enquire about equivalent substitute medication (generic as apposed to patented medication).
- Determine, before treatment, if you will be charged the Scheme Rate.
- 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. Your Scheme will not pay for duplicated tests.
- Keep a record of all claims submitted.

The Correct Claims Procedure

You must please submit your claim directly to the Scheme at:
PG Group Medical Scheme
PO Box 1402
Durban
4000

OR deposit the claim into the dedicated on-site collection box
OR email claims separately to **claims@pggmeds.co.za** (zipped files are not accepted – **please include one claim per email to ensure that all claims are received**).

Original prescriptions have to be submitted. Submit your claims promptly as all claims expire at the end of the fourth month after date of treatment. Approved claims will be paid within 30 days of receipt.

Members must ensure that all accounts 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 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).

Copies of all submitted claims should be retained by the member. The onus rests on the members to check their claims statement to ensure that payments have been made. It is also the responsibility of members to inform the service provider (doctor, pharmacist, etc.) of the correct name and address of the Scheme and the medical scheme reference number.

Payment of Claims - Scheme Rate

Claims for services supplied by healthcare providers who charge in accordance with the Scheme Rate will be paid directly to the healthcare providers, whilst claims for services provided by healthcare providers who charge in excess of the Scheme Rate will be paid to the member. In this instance, it is the member's responsibility to settle the healthcare provider's account in full.

Members who pay cash to a healthcare provider for treatment and/or medication are required to attach a signed receipt to their 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 the member.

Remember the ICD-10 Codes

All healthcare providers are required, by law, to indicate ICD-10 codes on all accounts and next to each medicine item on a prescription. Even if you submit a claim after having paid for the services yourself, a valid applicable ICD-10 code should be indicated on the account. 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 doctor that he/she has indicated the correct ICD-10 codes on all prescriptions and accounts. Also check your claims statements regularly to ensure that claims have been paid. A claim on which the ICD-10 codes are missing or the incorrect ICD-10 codes have been indicated, will be rejected and a modified account 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

PG Group Medical Scheme does not provide cover for the following:

- 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.
- 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 can be recovered from a third party.
- Participation in medical research.
- Patent, proprietary drugs and bandages, patent food preparations, and domestic and biochemical remedies.
- Sunglasses.
- Tonic and mineral supplements.
- Treatment of infertility and artificial insemination.
- Wilful, self-inflicted injury.

Underwriting

Waiting periods and exclusions fall under the broader heading of “underwriting” and are measures prescribed by law, in this case the Medical Schemes Act, which allow medical schemes to protect their financial well-being. 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 and, having not contributed to the reserve of the medical scheme, to be able to claim and have these claims met by the reserves that existing members have built over a period. 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 to be able to claim further.

The Rules state that anyone who joins a medical scheme, other than as a result of changing jobs, will not be able to claim from the medical scheme for the first three months (general waiting period). In addition, the medical scheme will not pay any claim that arises in the first 12 months for any condition that pre-existed prior to the member joining (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 never belonged to any medical scheme previously or having 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 their monthly contribution. This can be as high as 75% and will remain in force for the duration of their membership. Should this member join another medical scheme, the penalty will continue to apply.

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

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

Medical Savings Account

A fixed amount is allocated to your medical savings account (MSA) for every month in the year. The total amount for the year is available at the beginning of the year if members are registered from 1 January. If this is not the case, the amount in your MSA will be pro rated according to the number of months in that year that you are a member of the Scheme.

If you have funds in your MSA at the end of the year, this amount will be carried over and added to your balance for the following year. In this way, being careful with your MSA funds will enable you to build up a considerable balance over time. If you leave 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 component, your remaining funds will be transferred to your new medical scheme.

Should you leave the Scheme during the year and have already spent the entire amount for the year, you will be required to refund the difference between the total amount and the entitlement due on your date of termination to the Scheme. The 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 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 auxilliary services; and
- speech and occupational therapy.

What About Claims Deducted from your MSA?

Where your doctor charges Scheme Rates, the Scheme will pay your doctor directly – unless you have paid and a receipt is attached to the account. In the case of your doctor charging private rates (more than the Scheme Rate), you need to settle the account directly with the healthcare provider and you will be refunded the appropriate benefit at the Scheme Rate. The MSA cannot be used to pay for PMBs, including co-payments related to PMBs.

Important Notes on MSA

Members contribute a portion of their monthly contribution into the MSA. Members have an overdraft facility up to the value of their total annual savings balance for the current year, available from the first day of the year. Please note that if your employment is terminated during the year, you will be liable to repay any amount advanced. Similarly, if you resign from the Scheme during the year and have used your full year's entitlement of benefits (which you have not yet contributed to), you will need to pay to the Scheme the portion of contribution that is still outstanding. 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 any cash payments of these balances back to you, unless you resign from the Scheme. Should you join another medical scheme with a savings facility, you are required to transfer any money you have accumulated to your new medical scheme.

The Scheme continues to pay interest on positive saving balances. Members are not charged interest on negative balances.

Note: Payment for acute medication will automatically be paid from savings.

Pro-rata Apportionment

If you join the Scheme as a new member in the middle of 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. Similarly, if you leave the Scheme during the year and you have depleted your benefits, you will then owe the Scheme the portion of contributions that has not been paid, if any.

Optical Benefits

Preferred Provider Negotiators (PPN), South Africa's largest optometric network, will provide 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 **0860 10 35 29** or **0861 10 14 77**.

At a PPN provider, each beneficiary is entitled to a composite consultation and EITHER a PPN frame to the value of R150 plus R700 of lens enhancements or R850 towards an alternative frame and/or lens enhancements and a pair of clear single vision, bi-focal or multi-focal lenses, OR contact lenses. Scripts less than 0.50 diopter will not be covered. Members joining mid-cycle will be entitled to a pro-rated benefit, depending on the joining date.

For the benefit cycle of 24 months from date of claiming, each beneficiary is entitled to:

In and Out of Network	
Frame and/or lens enhancements	R850
One pair of clear acquity single vision lenses; **or**	R150 per lens
One pair of clear acquity bi-focal lenses; **or**	R325 per lens
One pair of multi-focal lenses	R600 per lens
OR	
Contact lenses	R1 560
Contact lens re-examination (subject to Scheme Rules and can only be claimed in six-monthly intervals)	R200 x 3

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

In-network Benefits

- One composite consultation (inclusive of refraction, tonometry and visual fields screening, inclusive of dispensing within benefit incentive) and either spectacles or contact lenses. These claims will be paid at 100% of benefit limits prescribed.
- Readymade readers: two pairs (in a two-year cycle) – R75 per pair.

Out-of-network Benefits

- One consultation paid at R325 and either spectacles or contact lenses.

The following questions will ensure that you optimise your optical benefit and reduce the chances of any co-payment:

1. Ask if your optometrist forms part of the PPN network.
2. Ask your optometrist about the acquity range of lenses. Remember that clear multi-focal lenses are covered up to the cost of clear bi-focal lenses.
3. Ask your optometrist to show you the PPN range of frames.

Please submit all optical claims to:

Post: Preferred Provider Negotiators, PO Box 12450, Centrahil, Port Elizabeth 6006
Fax: **041 506 5750**
Email: **claims@ppn.co.za**

Please note: Shortfalls can still be paid from positive savings. These requests need to be forwarded directly to PPN.

PPN
Preferred Provider Negotiators

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 dentist will also be able to provide information regarding your benefits, as Denis supplies all dentists with a Chair Side and Benefit Guide, which illustrates the dental benefits for 2016.

Maxillofacial and Oral Surgery

These relevant health services (unless otherwise limited or excluded) are regarded as a specialist medical service and will only apply in respect of cancer cases.

Dentistry

All claims will be paid at the PDT, which is published annually and distributed by Denis.

Conservative Dentistry

- **Consultations, oral hygiene, X-rays, fillings or extractions**: Covered at the PDT. Two annual check-ups per beneficiary (once every six months). Motivation may be requested for extensive restorative (fillings) treatment plans.
- **Root canals**: Covered at the PDT.
- **Plastic dentures**: One per jaw in a four-year period per beneficiary.

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.
- **Metal frame dentures**: Two frames per beneficiary in a five-year period.
- **Orthodontics (fixed braces)**: R12 100 per beneficiary per lifetime will apply to each case assessed as severe according to the orthodontic index. Limited to individuals 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 100 per implant. Subject to pre-authorisation.
- **Surgery in dental rooms**: Covered at the PDT.

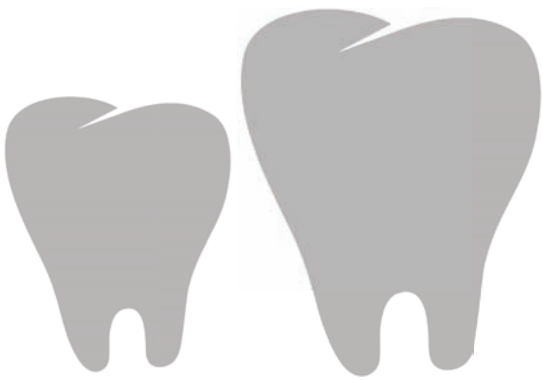
Hospitalisation and Anaesthetics

- **General anaesthetic in hospital**: Subject to pre-authorisation. Admission protocols apply.
- **Laughing gas in dental rooms**: Covered at the PDT.
- **IV conscious 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, Cape Town 7446
Fax: **0866 77 03 36**
Email: **claims@denis.co.za**

Please note: Shortfalls will automatically be paid from positive savings.



PG Group Medical Scheme Wellness Benefit

Benefit	ICD-10	Limits	2016
Immunisation Programmes			
Baby immunisation programme	-	As required by the Department of Health	Covered for the first six years of life
Flu vaccines	Z251	Once a year	All beneficiaries
Tetanus diphtheria booster	Z235	As needed	All beneficiaries
Pneumococcal vaccination	Z238	As needed	Beneficiaries 60 years and older and high-risk beneficiaries
Early Detection Programmes			
General physical examination (General practitioner) Tariff codes 190 - 192 Tariff code 4188 - Urine dipstick test	Z000	One medical examination every five years	Adults 21 to 29 years
		One medical examination every three years	Adults 30 to 59 years
		One medical examination every two years	Adults 60 to 69 years
		One medical examination every year	Adults 70 years and older
Prostate specific antigen test (Pathologist) Tariff codes 4519 & 4524	Z125	Every five years Every three years Every two years Every year	Males 40 to 49 years Males 50 to 59 years Males 60 to 69 years Males 70 years and older
Cholesterol test (Pathologist) Tariff codes 4026, 4027, 4147 & 4025	Z136	Once a year	All adult beneficiaries
Blood sugar glucose test (Pathologist) Tariff codes 4050 & 4057	Z131	Once a year	All adult beneficiaries
Pap smear (Pathologist) Tariff code 4566	Z014	Once a year	Females 15 years and older

Benefit	ICD-10	Limits	2016
Early Detection Programmes (continued)			
OR **Pap smear consultation** (General practitioner/gynaecologist) Tariff codes 190 - 192	Z014	Once a year	Females 15 years and older
Mammogram (Radiology) Tariff codes 34100 & 34101	Z016	Every two years Once a year	Females 40 years and older Females with risk factors
OR **Mammogram** (General practitioner/gynaecologist) Tariff code 3605	Z016	Every two years Once a year	Females 40 years and older Females with risk factors
DEXA scan/bone density (Radiologist) Tariff code 50120	Z016	Once every three years	Beneficiaries 50 years and older
OR **DEXA scan/bone density** (General practitioner/gynaecologist) Tariff code 3604	Z016	Once every three years	Beneficiaries 50 years and older
Glaucoma test Tariff code 3014	Z135	Once every two years Annually	Beneficiaries 40 to 49 years Beneficiaries 50 years and older
HIV test (Pathologist) Tariff code 3932	Z114	Once every five years	Beneficiaries 15 years and older
Maternity Programme (subject to **compulsory registration** on the Maternity Programme)			
Antenatal visits (General practitioner/gynaecologist) Tariff codes 190 - 192	-	12 visits	Registered women
OR **Antenatal visits** (Midwives) Tariff code 88420	-	12 visits	Registered women
Urine test (General practitioner/gynaecologist) Tariff code 4188	-		Registered women
Scans - one before the 24th week and one after the 24th week (Radiologist) Tariff codes 43250, 43260, 43270, 43273 & 43277	-	Two scans	Registered women
OR **Scans** - one before the 24th week and one after the 24th week (General practitioner/gynaecologist) Tariff codes 5106, 5107, 5108, 3615 & 3617	-	Two scans	Registered women
Paediatrician visits Tariff codes 190 - 192	-	Two visits in baby's first year	Babies up to 12 months registered on the Programme

2016 Contributions

Total Consolidated Contribution Table

Gross Income	Member	Adult Dependant	Child Dependant
R0 - R3 700	R1 620	R1 620	R430
R3 701 - R6 300	R2 050	R2 050	R550
R6 301 - R9 000	R2 270	R2 270	R570
R9 001 - R12 100	R2 450	R2 450	R610
R12 101 - R15 200	R2 600	R2 600	R630
R15 201 +	R2 700	R2 700	R650

Monthly Member Medical Savings Account Contribution Table

Gross Income	Member	Adult Dependant	Child Dependant
R0 - R3 700	R375	R375	R100
R3 701 - R6 300	R475	R475	R128
R6 301 - R9 000	R525	R525	R133
R9 001 - R12 100	R568	R568	R140
R12 101 - R15 200	R600	R600	R145
R15 201 +	R625	R625	R150

Please note

This summary 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.

CMS
Council for Medical Schemes

Contact Details and 2016 Benefits

Scheme Contact Details

Claims and Administration
Postal address for claims and correspondence:
PG Group Medical Scheme
PO Box 1402
Durban
4000

Regional Office Durban
1-3 Canegate Road
La Lucia Ridge
4019

Customer Care
0860 00 50 37
fax: 0861 64 77 75
email: info@pggmeds.co.za

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

Hospitalisation and Pre-authorisation
0860 00 50 37

Chronic Medication Registration and Queries
Medicine Risk Management (MRM)
0860 00 50 37
fax: 031 580 0597
email: pggmrm@mhg.co.za

Emergency Assistance and Ambulance
Netcare 911
082 911

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

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

Denis Dental Management
0860 10 49 39
email: claims@denis.co.za

Preferred Suppliers of Chronic Medication

Arcadia Pharmacy
011 815 5630
PO Box 990
Springs
1560

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

Schuin-Villa Pharmacy
041 364 2109
PO Box 7824
Port Elizabeth
6055

Gap Cover

Admed Gap Cover
PO Box 786015
Sandton
2146

0860 102 936
email: admed@guardrisk.co.za

Travel Cover

Travel Insurance Consultants (TIC)
For travel certificate: 011 521 4000
email: helpdesk@tic.co.za

Incident Notification/Claims Line
011 991 8409

One-stop Shop Number
0860 00 50 37

PG Group Medical Scheme members can dial this number for any Scheme queries.

Monday - Friday
07h00 to 17h00

Saturdays
07h00 to 12h00

The following options are available to you:

Option 1	PPN
Option 2	Denis
Option 3	Pre-authorisation (Medical)
Option 4	All other queries

2016 Benefits

PG GROUP MEDICAL SCHEME

OVERALL ANNUAL LIMIT (OAL)

R400 000 per beneficiary

TREATMENT RECEIVED WHEN ADMITTED TO HOSPITAL:	LIMITS	PAID FROM	PRE-AUTH
PRE-AUTHORISATION NECESSARY IN ALL CASES Emergencies must be authorised within 48 hours of being admitted. Failure to pre-authorise will result in the member being liable for the full cost of hospitalisation and related expenses. Benefits will be provided in accordance with the Rules, benefits, clinical protocols and limits of the Scheme.			
HOSPITALISATION Including ward and theatre fees, ICU and HCW, drugs, 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 specified 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 member.**	100% of Scheme Rate	Common Benefits Subject to OAL	Yes
MATERNITY BENEFITS (CONFINEMENTS IN HOSPITAL) Normal deliveries and caesarean sections in private and provincial 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 Scheme Rate	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 (GP), technicians and physiotherapy. Excluding costs for maxillofacial and oral surgery, except in cancer cases.	100% of Scheme Rate	Common Benefits Subject to OAL	Yes
AMBULANCE SERVICE (EMERGENCY SERVICES) Road ambulances, emergency services, general advice line, air evacuation and transportation. **(Pre-authorisation required – contact Netcare 911 on 082 911.)**	100% of Scheme Rate R2 480 per family if Netcare 911 is not used	Common Benefits Through approved provider only	Yes
INTERNAL PROSTHESIS AND APPLIANCES Including pacemakers, electronic devices, coronary stents and joint replacements.	100% of agreed costs	R40 000 per family per annum Subject to OAL	Yes

RENAL DISORDERS (KIDNEY AND HOME DIALYSIS) Including related drug therapy (through approved providers only). **All cases subject to full investigation, registration on the Renal Programme and pre-authorisation.**	100% of Scheme Rate	R176 400 per family Subject to OAL	Yes
ORGAN TRANSPLANTS (SUBJECT TO PRESCRIBED MINIMUM BENEFITS) Including organ harvesting and immunosuppressive drug therapy. Subject to transplant motivation, Prescribed Minimum Benefits (PMBs) and pre-authorisation required.	100% of Scheme Rate	R176 400 per family Subject to OAL	Yes
PSYCHIATRY IN AND OUT OF HOSPITAL INCLUDING PSYCHOLOGICAL CONDITIONS Hospitalisation conditions include anorexia nervosa, bulimia, alcoholism, treatment for alcohol and chemical abuse, and all related accounts at approved facilities.	100% of Scheme Rate	R37 350 per family Subject to OAL Limited to 21 days only	Yes
TREAMENT RECEIVED IN ROOMS WHEN NOT ADMITTED TO HOSPITAL:	**LIMITS**	**PAID FROM**	**PRE-AUTH**
CONSULTATIVE SERVICES (SPECIALIST TREATMENT) Specialist conditions and treatment out of hospital by anaesthetists, physicians, neurosurgeons, surgeons, orthopaedic specialists, otorinolaryncologists (ENT), radiotherapists, thoracic surgeons, urologists and cardiologists.	100% of Scheme Rate	M: R3 165 M+1: R5 170 M+2: R6 330 M+3: R6 805 Subject to OAL	–
GENERAL PRACTITIONERS AND CERTAIN SPECIALISTS Out patients, out-of-hospital consultations, treatment in rooms and procedures in doctors' rooms. Dermatologists, gynaecologist, 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 doctor's practice number to appear on all claims.** **(Pre-authorisation required for MRI, bone densitometry, mammograms and CT scans.)**	100% of Scheme Rate	M: R12 340 M+1: R20 470 M+2: R23 105 M+3: R28 910 Subject to OAL	Yes
ONCOLOGY Chemotherapy, radiotherapy, intravenous drugs and materials. **This benefit is subject to the submission and approval of a comprehensive treatment plan.** **To be sent to the Pre-authorisation Department via fax on 031 580 0591 or post to PO Box 1402, Durban 4000.**	100% of Scheme Rate	R176 400 per beneficiary per year Subject to OAL	Yes
CHRONIC PRESCRIBED MEDICATION Medication prescribed or dispensed to patients registered on the chronic medication programme with the Scheme.	100% of SEP and dispensing fee	M: R18 463 M+1: R30 701 M+2: R36 820 M+3: R43 100 Subject to OAL	Yes

HIV/AIDS Antiretroviral treatment (ART). **Compulsory registration on HIV YourLife Programme.**	100% of cost	Unlimited Subject to registration and pre-authorisation	Yes
ACUTE MEDICATION All medication including TTOs **(maximum six days supply)** other than those obtained by members through Medicine Risk Management. Medication prescribed and dispensed by pharmacists limited to R140 per prescription (PAT). Clinical and pharmacy dispensed vaccinations.	100% of SEP and dispensing fee	Subject to available MSA	–
PHYSIOTHERAPY/BIOKINETICS **On referral by a GP.**	100% of Scheme Rate	Subject to available MSA	Yes
EXTERNAL APPLIANCES Includes nebulisers, wheelchairs, stoma products, hearing protectors and home oxygen. **(Pre-authorisation required.)**	100% of cost	R5 275 per family per annum	Yes
HEARING AIDS **(Pre-authorisation required.)**	100% of cost	R12 000 per ear per beneficiary every three years	Yes
COMMUNITY CARE:	**PAID FROM**	**LIMITS**	**PRE-AUTH**
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 doctor's comprehensive treatment plan and Scheme approval.**	100% of cost	Subject to OAL	Yes
FRAIL CARE – Subject to doctor's letter of motivation and Scheme approval.			
REHABILITATION **Subject to submission and approval of a treatment plan.**	100% of Scheme Rate	27 days per family per annum	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 and fall within the Overall Annual Limit.			

ABBREVIATIONS: **MSA** = Medical Savings Account **MMAP** = Maximum Medical Aid Price **OAL** = Overall Annual Limit **SEP** = Single Exit Price

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