MEDSHIELD
medical scheme

premium plus

2018 BENEFIT GUIDE

MEDSHIELD Premium Plus Benefit Option

You never know when you or your family member/s may require medical care or treatment and, most importantly, whether you will have funds readily available to cover the costs.
The 2018 Benefits were designed with the member's interest at heart, taking into consideration what the members need and what medical services are available in the healthcare space.

Families and corporate individuals can rest assured that our **Premium Plus** option will fulfil all their healthcare needs! This option offers unlimited In-Hospital cover, with certain In-Hospital procedures paid at a higher rate (Medshield Private Tariff 200%), than the Medshield Tariff (100%). This plan allows you to manage your Out-of-Hospital medical requirements through a Personal Savings Account.

This is an overview of the benefits offered on the **Premium Plus** option:

Wellness
Benefits

Major Medical
Benefits
(In-Hospital)

Oncology
Benefits

Chronic Medicine
Benefits

Ambulance
Services

Maternity
Benefits

What you need to know as a member

- Carefully read through this guide and use it as a reference for more information on what is covered on the **Premium Plus** option, the benefit limits, and the rate at which the services will be covered
- All hospital admissions must be pre-authorised 72 hours prior to admission by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701)
- Your cover for hospitalisation includes accommodation, theatre costs, hospital equipment, theatre or ward drugs, pharmaceuticals and/or surgical items
- Hospitalisation easily accessible for your peace of mind
- Pre-authorisation is not a guarantee of payment and Scheme rules/protocols will be applied where applicable
- Specialist services from treating/attending Specialists are subject to pre-authorisation
- If you do not obtain a pre-authorisation or retrospective authorisation in case of an emergency, you will incur a percentage penalty
- Your Day-to-Day benefits consist of a Personal Savings Account for Out-of-Hospital services, a Self-payment Gap Cover and Above Threshold Benefit will apply on specified benefits
- Our Contact Centre Agents are available to assist should you require clarity on your benefits

Your claims will be covered as follows:

Medicines paid at 100% of the lower of the cost
of the SEP of a product plus a negotiated dispensing fee, subject to the use of the Chronic DSP and Managed Healthcare protocols.

Treatment and consultations will be paid at 100%
of the negotiated fee, or, in the absence of such fee, 100% of the lower of the cost or Scheme Tariff.

Extended Benefit Cover (up to 200%)
will apply to the following In-Hospital services (as part of an authorised event):

- Surgical Procedures
- Confinement
- Consultations and visits by General Practitioners and Specialists
- Maxillo-facial Surgery
- Non-surgical Procedures and Tests

Medshield Private Tariff (up to 200%)
will apply to the following services:

- Confinement by a registered Midwife
- Non-surgical Procedures (Refer to Addendum B for the list of services)
- Routine Diagnostic Endoscopic Procedures (Refer to Addendum B or a list of services)

PremiumPlus

The application of co–payments

The following services will attract upfront co-payments:

Non-PMB Internal Prosthesis and Devices	**25% upfront** co-payment
Non-PMB PET and PET-CT scan	**10% upfront** co-payment
Voluntary use of a non-DSP for HIV & AIDS related medication	**40% upfront** co-payment
Voluntary use of a non-DSP or a non-Medshield Pharmacy Network	**40% upfront** co-payment
Out of formulary medication voluntarily obtained	**40% upfront** co-payment
Oncology - voluntary use of a non-ICON provider	**40% upfront** co-payment

Please note: Failure to obtain an authorisation prior to hospital admission or surgery and/or treatment (except for an emergency), will attract a 20% penalty.

GAP Cover

Gap Cover assists in paying for certain shortfalls not covered by the Scheme based on Scheme Rules.
Assistance is dependent on the type of Gap Cover chosen. Medshield members can access Gap Cover through their Brokers.

MAJOR Medical Benefits – In-Hospital

BENEFIT CATEGORY	BENEFIT LIMIT AND COMMENTS
OVERALL ANNUAL LIMIT	**Unlimited.**
EXTENDED BENEFIT COVER (up to 200%)	For specified services and procedures only where a beneficiary is hospitalised.
HOSPITALISATION Subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701). **Clinical Protocols apply.**	**Unlimited.** Specialist services from treating/attending Specialists are subject to pre-authorisation.
SURGICAL PROCEDURES As part of an authorised event.	**Unlimited.** **Extended Benefit Cover (up to 200%)**
MEDICINE ON DISCHARGE FROM HOSPITAL Included in the hospital benefit if on the hospital account or if obtained from a Pharmacy on the day of discharge.	Limited to **R750** per admission. According to the Maximum Generic Pricing or Medicine or Medicine Price List and Formularies.
ALTERNATIVES TO HOSPITALISATION Treatment only available immediately following an event. Subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701). **Includes the following:** • **Physical Rehabilitation** • **Sub-Acute Facilities** • **Nursing Services** • **Hospice** • **Terminal Care** **Clinical Protocols apply.**	**R120 000** per family per annum. **R31 800** per family per annum. Subject to the Alternatives to Hospitalisation Limit.
GENERAL, MEDICAL AND SURGICAL APPLIANCES Service must be pre-approved or pre-authorised by the Scheme on 086 000 2120 (+27 10 597 4701) and must be obtained from the DSP, Network Provider or Preferred Provider. **Hiring or buying of Appliances, External Accessories and Orthotics:** • **Peak Flow Meters, Nebulizers, Glucometers and Blood Pressure Monitors** (motivation required) • **Hearing Aids** (including repairs) • **Wheelchairs** (including repairs) • **Stoma Products and Incontinence Sheets related to Stoma Therapy** • **CPAP Apparatus for Sleep Apnoea** Subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701) and services must be obtained from the Preferred Provider. **Clinical Protocols apply.**	**R5 670** per family per annum. **R750** per beneficiary per annum. Subject to Appliance Limit. Subject to Appliance Limit. Subject to Appliance Limit. Unlimited if pre-authorised. Subject to Appliance Limit.
OXYGEN THERAPY EQUIPMENT Subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701) and services must be obtained from the DSP or Network Provider. **Clinical Protocols apply.**	**Unlimited.**
HOME VENTILATORS Subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701) and services must be obtained from the DSP or Network Provider. **Clinical Protocols apply.**	**Unlimited.**

MAJOR Medical Benefits – In-Hospital

BENEFIT CATEGORY	BENEFIT LIMIT AND COMMENTS
BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS **(Including emergency transportation of blood)** Subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701) and services must be obtained from the DSP or Network Provider. **Clinical Protocols apply.**	**Unlimited.**
MEDICAL PRACTITIONER CONSULTATIONS AND VISITS As part of an authorised event during hospital admission, including Medical and Dental Specialists or General Practitioners.	**Unlimited.** **Extended Benefit Cover (up to 200%)**
REFRACTIVE SURGERY Subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701). **Includes the following:** • **Lasik** • **Radial Keratotomy** • **Phakic Lens Insertion** **Clinical Protocols apply.**	**R15 400** per family per annum. Including hospitalisation, if not authorised, payable from Personal Savings Account.
SLEEP STUDIES Subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701). **Includes the following:** • **Diagnostic Polysomnograms** • **CPAP Titration** **Clinical Protocols apply.**	 **Unlimited.** **Unlimited.**
ORGAN TISSUE AND HAEMOPOIETIC STEM CELL (BONE MARROW) TRANSPLANTATION Subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701) a Centre of Excellence. **Includes the following:** • **Immuno-Suppressive Medication** • **Post Transplantation and Biopsies and Scans** • **Related Radiology and Pathology** **Clinical Protocols apply.**	**Unlimited.** Organ harvesting is limited to the Republic of South Africa. Work-up costs for donor in Solid Organ Transplants included. No benefits for international donor search costs. Haemopoietic stem cell (bone marrow) transplantation is limited to allogenic grafts and autologous grafts derived from the South African Bone Marrow Registry.
PATHOLOGY AND MEDICAL TECHNOLOGY As part of an authorised event. **Clinical Protocols apply.**	**Unlimited.**
PHYSIOTHERAPY As part of an authorised event.	**Unlimited.**
PROSTHESIS AND DEVICES INTERNAL Subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701) and services can be obtained from the Medshield Hospital Network. **Surgically Implanted Devices.** **Clinical Protocols apply.**	**R56 700** per family per annum. **25% upfront co-payment** for non-PMB. **Sub-limits may apply.**
PROSTHESIS EXTERNAL Services must be pre-approved or pre-authorised by the Scheme on 086 000 2120 (+27 10 597 4701). **Including Ocular Prosthesis.** **Clinical protocols apply.**	Subject to Prosthesis and Devices Internal Limit. No co-payment applies to External Prosthesis.

BENEFIT CATEGORY	BENEFIT LIMIT AND COMMENTS
LONG LEG CALLIPERS Service must be pre-approved or pre-authorised by the Scheme on 086 000 2120 (+27 10 597 4701) and must be obtained from the DSP, Network Provider or Preferred Provider.	Subject to Prosthesis and Devices Internal Limit. No co-payment applies to External Prosthesis.
GENERAL RADIOLOGY As part of an authorised event. **Clinical Protocols apply.**	**Unlimited.**
SPECIALISED RADIOLOGY Subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701). **Includes the following:** • **CT scans, MUGA scans, MRI scans, Radio Isotope studies** • **CT Colonography (Virtual Colonoscopy)** • **Interventional Radiology replacing Surgical Procedures** **Clinical Protocols apply.**	**R22 840** per family per annum. Subject to Specialised Radiology Limit. No co-payment applies to CT Colonography. **Unlimited.**
CHRONIC RENAL DIALYSIS Subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701) and services must be obtained from the DSP or Network Provider. **Haemodialysis and Peritoneal Dialysis includes the following:** **Material, Medication, related Radiology and Pathology** **Clinical Protocols apply.**	**Unlimited.** **40% upfront co-payment** for the use of a non-DSP. Use of a DSP applicable from Rand one for PMB and non-PMB.
NON-SURGICAL PROCEDURES AND TESTS As part of an authorised event.	**Unlimited.** **Extended Benefit Cover (up to 200%)**
MENTAL HEALTH Subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701). Up to a maximum of **3 days** if patient is admitted by a General Practitioner. • **Rehabilitation for Substance Abuse** **1 rehabilitation programme per beneficiary per annum** • **Consultations and Visits, Procedures, Assessments, Therapy, Treatment and/or Counselling**	**R50 000** per family per annum. DSP applicable from Rand one for PMB and non-PMB admissions. **R12 720** per family per annum. Limited to and included in the Mental Health Limit. Subject to Mental Health Limit.
HIV & AIDS Subject to pre-authorisation and registration with the relevant Managed Healthcare Programme on 086 050 6080 (+27 11 912 1000) and must be obtained from the DSP. **Includes the following:** • **Anti-retroviral and related medicines** • **HIV/AIDS related Pathology and Consultations** • **National HIV Counselling and Testing (HCT)**	As per Managed Healthcare Protocols. Out of formulary PMB medication voluntarily obtained or PMB medication voluntarily obtained from a provider other than the DSP will have a **40% upfront co-payment**.
INFERTILITY INTERVENTIONS AND INVESTIGATIONS Subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701) and services must be obtained from the DSP. **Clinical Protocols apply.**	Limited to interventions and investigations only. **Refer to Addendum A** for a list of procedures and blood tests.
BREAST RECONSTRUCTION (following an Oncology event) Subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701) and services must be obtained from the DSP or Network Provider. **Post Mastectomy** (including all stages) **Clinical Protocols apply.**	**R80 000** per family per annum. **Extended Benefit Cover up to 200%** Co-payment and Prosthesis limit, as stated under Prosthesis, is not applicable for breast reconstruction.

MATERNITY Benefits

Benefits will be offered during pregnancy, at birth and after birth. Subject to pre-authorisation with the relevant Managed Healthcare Programme prior to hospital admission. Benefits are allocated per pregnancy subject to the Overall Annual Limit, unless otherwise stated.

BENEFIT CATEGORY	BENEFIT LIMIT AND COMMENTS
ANTENATAL CONSULTATIONS	**12 Antenatal** consultations per pregnancy.
ANTENATAL CLASSES	**R500** per family.
PREGNANCY RELATED SCANS AND TESTS	**Limited to the following:** **Two** 2D Scans per pregnancy. **1 Amniocentesis** per pregnancy.
CONFINEMENT AND POSTNATAL CONSULTATIONS Subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701).	
• **Confinement in hospital** • **Delivery by a General Practitioner or Medical Specialist** • **Confinement in a registered birthing unit or Out-of-Hospital**	**Unlimited.** **Unlimited.** **Unlimited.** **Extended Benefit Cover (up to 200%)**
- Midwife consultations per pregnancy	**4 Postnatal** consultations per pregnancy.
- Delivery by a registered Midwife or a Practitioner	**Medshield Private Rates (up to 200%)** applies to a registered Midwife only.
- Hire of water bath and oxygen cylinder	**Unlimited.**
Clinical Protocols apply.	

ONCOLOGY Benefits

This benefit is subject to the submission of a treatment plan and registration on the Oncology Management Programme (ICON).
You will have access to post active treatment for 36 months.

BENEFIT CATEGORY	BENEFIT LIMIT AND COMMENTS
ONCOLOGY LIMIT (**40% upfront co-payment** for the use of a non-DSP)	**Unlimited.**
• **Active Treatment** Including Stoma Therapy, Incontinence Therapy and Brachytherapy.	Subject to Oncology Limit. **ICON Enhanced** Protocols apply.
• **Oncology Medicine**	**R318 000** per family per annum. Subject to Oncology Limit. **ICON Enhanced** Protocols apply.
• **Radiology and Pathology** Only Oncology related Radiology and Pathology as part of an authorised event.	Subject to Oncology Limit.
• **PET and PET-CT** Limited to **1 Scan** per family per annum.	**R20 225** per family per annum. **10% upfront co-payment** for non-PMB.
INTEGRATED CONTINUOUS CANCER CARE Social worker psychological support during cancer care treatment.	**6 visits** per family per annum. Subject to Oncology Limit.
SPECIALISED DRUGS FOR ONCOLOGY NON-ONCOLOGY AND BIOLOGICAL DRUGS	Subject to Oncology Medicine Limit.
• **Macular Degeneration** **Clinical Protocols apply.**	**R40 000** per family per annum. Subject to Oncology Limit.

CHRONIC MEDICINE Benefits

Covers expenses for specified chronic diseases which require ongoing, long-term or continuous medical treatment.

Registration and approval on the Chronic Medicine Management Programme is a **pre-requisite to access this benefit**.

Contact the Managed Healthcare Provider on 086 000 2120 (+27 10 597 4701). Medication needs to be obtained from a Medshield Pharmacy Network Provider.

40% Upfront co-payment
will apply in the following instances:

- Out of formulary medication voluntarily obtained.
- Medication voluntarily obtained from a non Medshield Pharmacy Network Provider.

This option covers medicine for all 26 PMB CDLs and an additional list of 54 conditions.

Re-imbursement at Maximum Generic Price
or Medicine Price List and Medicine Formularies.
Levies and co-payments to apply where relevant.

BENEFIT CATEGORY	BENEFIT LIMIT AND COMMENTS
• The use of a Medshield Pharmacy Network Provider is applicable from Rand one. • Supply of medication is limited to **one month** in advance.	**R12 625** per beneficiary per annum limited to **R25 245** per family per annum. Medicines will be approved in line with the Medshield **Comprehensive Formulary** within limits, thereafter the **Restrictive Formulary** is applicable.

DENTISTRY Benefits

Provides cover for Dental Services according to the Dental Managed Healthcare Programme and Protocols.

BENEFIT CATEGORY	BENEFIT LIMIT AND COMMENTS
BASIC DENTISTRY • **In-Hospital** (only for beneficiaries under the age of 6 years old) Subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701). Failure to obtain an authorisation prior to treatment will result in a 20% penalty. According to the Dental Managed Healthcare Programme and Protocols. • **Out-of-Hospital** According to the Dental Managed Healthcare Programme and Protocols.	**Unlimited**. **Medshield Private Rates (up to 200%)** applies to the Dentist account only when procedure is performed under concious sedation in the Practitioners' rooms. Subject to Personal Savings Account. Threshold and Above Threshold apply.
SPECIALISED DENTISTRY All below services are subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701). Failure to obtain an authorisation prior to treatment will result in a 20% penalty. According to the Dental Managed Healthcare Programme and Protocols.	**R15 900** per family per annum.
• **Wisdom Teeth and Apicectomy** Wisdom Teeth. Apicectomy only covered in the Practioners' rooms. Subject to pre-authorisation.	Subject to the Specialised Dentistry Limit. **Medshield Private Rates (up to 200%)** applies to the Dentist account only when procedure is performed under concious sedation in the Practitioners' rooms.
• **Dental Implants** Includes all services related to Implants. Subject to pre-authorisation.	Subject to the Specialised Dentistry Limit. **Medshield Private Rates (up to 200%)** applies to the Dentist account only when procedure is performed under concious sedation in the Practitioners' rooms.
• **Orthodontic Treatment** Subject to pre-authorisation.	Subject to the Specialised Dentistry Limit.
• **Crowns, Bridges, Inlays, Mounted Study Models, Partial Metal Base Dentures and Periodontics** Consultations, Visits and Treatment for all such dentistry including the Technicians' Fees. Subject to pre-authorisation.	Subject to Personal Savings Account. Threshold and Above Threshold apply.
MAXILLO-FACIAL AND ORAL SURGERY All services are subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701). **Non-elective surgery only.** According to the Dental Managed Healthcare Programme and Protocols.	**R15 900** per family per annum. **Extended Benefit Cover (up to 200%)** only applicable to Maxillo-facial Surgery.

OUT-OF-HOSPITAL Benefits

Provides cover for Out-of-Hospital services such as GP Consultations, Optical Services, Specialist Consultations and Acute Medication from your Personal Savings Account.

Your **PSA is 25% of your monthly contributions** and it is allocated annually in advance from January to December.

Medicines paid at 100% of the lower of the cost of the SEP of a product plus a negotiated dispensing fee, subject to the use of the Medshield Pharmacy Network and Managed Healthcare Protocols.

Treatment paid at 100% of the negotiated fee, or in the absence of such fee
100% of the cost or Scheme Tariff.

DAY-TO-DAY Benefits

Premium Plus offers various Day-to-Day benefit categories including a PSA and an Above Threshold Benefit. The benefits can be used to pay claims such as GP Consultations, Optical Services, Specialist Consultations, and Acute Medication.

Your Day-to-Day benefits are structured as follows:

BENEFIT COMPONENT	MEMBER	+ ADULT	+ CHILD
Annual Personal Savings Account (PSA)	**R14 472**	**R13 248**	**R2 700**
Threshold	**R15 365**	**R14 040**	**R2 875***
Above Threshold Benefit (ATB)	**R4 535**	**R3 400**	**R2 270***

Maximum Child Dependant Accumulation to the Threshold and Above Threshold Benefit Amount will be limited to three children

Benefit utilisation and how to access these Benefits

STEP 1 PERSONAL SAVINGS ACCOUNT (PSA)	• You will have access to your Personal Savings Account (PSA), which consists of 25% of your monthly contributions, allocated annually in advance (January to December) • Your PSA allocation is determined by your family size • Your PSA will be used to cover your Day-to-Day benefits • Once you and your dependant/s have exhausted your PSA, the Scheme has made an Above Threshold Benefit available that kicks in once you have reached the Threshold amount set by the Scheme
STEP 2 SELF-PAYMENT GAP (SPG)	• The Threshold amount is determined on an annual basis by the Scheme and some selected benefit categorie claims accumulate to the Threshold amount • In the event that your savings run out and you have not reached your Threshold amount, you will enter what is known as a Self-Payment Gap • Self-Payment Gap means you will be liable for payments of Day-to-Day medical expenses until you reach a threshold, meaning you will continue paying your claims from your pocket or your accumulated PSA up to the specified amount • Not all claims payable from your PSA or other Day-to-Day benefit categories accumulates to your threshold and Self-Payment Gap. Only claims marked on this brochure in accordance to Scheme rules will accumulate • The Self-Payment Gap will accumulate on Scheme tariff only • The Self-Payment Gap varies according to the family size, up to a pre-determined limit • You must continue to submit your claims even if you are in the Self-Payment Gap stage for your payments to reflect on the system in order for the accumulation to happen • Once you reach the Threshold amount you can then access to the Above Threshold Benefits
STEP 3 ABOVE THRESHOLD BENEFITS (ATB)	• Above Threshold Benefits is the next layer of benefits you can access once you reach your Threshold • The Scheme will pay for specified Day-to-Day medical expenses from the Above Threshold Benefit up to a pre-determined limit and not from Savings • All claims will be paid in accordance to the Scheme tariff • The Above Threshold Benefit limit also varies according to the family size • Once you have exhausted your Above Threshold Benefit and you have additional savings available, your claim will continue to be paid from Savings

Above Threshold Benefits (ATB) will be paid for the following benefits:

- Medical Specialist
- General Practitioner
- Acute Medicines (excluding over the counter medicine)
- Basic Dentistry and Specialised Dentistry
- Optical Services

DAY-TO-DAY Benefits

The following services are paid from your Day-to-Day benefits, unless a specific sub-limit is stated, all services accumulated on the Overall Annual Limit. Certain Benefit categories as stated below accumulate to the Threshold.

BENEFIT CATEGORY	BENEFIT LIMIT AND COMMENTS
GENERAL PRACTITIONER CONSULTATIONS AND VISITS	Subject to Personal Savings Account. Threshold and Above Threshold Benefit apply.
MEDICAL SPECIALIST CONSULTATIONS AND VISITS	Subject to Personal Savings Account. Threshold and Above Threshold Benefit apply.
CASUALTY/EMERGENCY VISITS Facility fee, Consultations and Medicine. If retrospective authorisation for emergency is obtained from the relevant Managed Healthcare Programme within 72 hours, benefits will be subject to Overall Annual Limit. Only bona fide emergencies will be authorised.	Subject to Personal Savings Account. Threshold and Above Threshold Benefit apply.
MEDICINES AND INJECTION MATERIAL • **Acute medicine** Medshield medicine pricing and formularies apply. • **Pharmacy Advised Therapy (PAT)**	Subject to Personal Savings Account. Threshold and Above Threshold Benefit apply. Limited to **R200** per script.
OPTICAL LIMIT Subject to relevant Optometry Managed Healthcare Programme and Protocols. • **Optometric refraction** (eye test) • **Spectacles and Contact Lenses:** (including repair costs) • Single Vision Lenses, Bifocal Lenses, Varifocal Lenses, Lens Add-ons, Contact Lenses • **Frames** (including repair costs) • **Readers:** If supplied by a registered Optometrist, Ophthalmologist, Supplementary Optical Practitioner or a Registered Pharmacy	Subject to Personal Savings Account. Threshold and Above Threshold Benefit apply. **1 test** per beneficiary per annum. Subject to Optical Limit. Subject to Optical Limit. Lenses Threshold Accumulation Limit of **R3 000** only. Subject to Optical Limit. **R150** per beneficiary per annum. Subject to Optical Limit.
PATHOLOGY AND MEDICAL TECHNOLOGY Subject to the relevant Pathology Managed Healthcare Programme and Protocols.	Subject to Personal Savings Account.
PHYSIOTHERAPY, BIOKINETICS AND CHIROPRACTICS	Subject to Personal Savings Account.
GENERAL RADIOLOGY Subject to the relevant Radiology Managed Healthcare Programme and Protocols.	Subject to Personal Savings Account. **1 Bone Densitometry scan** per beneficiary per annum in or out of hospital.
SPECIALISED RADIOLOGY Subject to pre-authorisation by the relevant Managed Healthcare Programme on 086 000 2121 (+27 10 597 4701).	Limited and included in the Specialised Radiology Limit of **R22 840** per family per annum.
NON-SURGICAL PROCEDURES AND TESTS • **Non-Surgical Procedures** • **Procedures and Tests in Practitioners' rooms** • **Routine Diagnostic Endoscopic Procedures in Practitioners' rooms**	Subject to Personal Savings Account. Threshold and Above Threshold Benefit apply. Subject to Personal Savings Account. Threshold and Above Threshold Benefit apply. **Unlimited.** **Medshield Private Rates (up to 200%)** **Refer to Addendum B** for a list of services. **Unlimited.** **Medshield Private Rates (up to 200%)** **Refer to the Addendum B** for the list of services.
MENTAL HEALTH Consultations and Visits, Procedures, Assessments, Therapy, Treatment and/or Counselling.	**R4 240** per family per annum. Limited to and included in the Mental Health Limit of **R50 000** per family.

DAY-TO-DAY Benefits

BENEFIT CATEGORY	BENEFIT LIMIT AND COMMENTS
MIRENA DEVICE Includes consultation, pelvic ultra sound, sterile tray, device and insertion thereof, if done on the same day. Subject to the **4 year** clinical protocols. Procedure to be performed in Practitioners' rooms. **On application only.**	**1 per female** beneficiary. Subject to Overall Annual Limit.
ADDITIONAL MEDICAL SERVICES Audiology, Dietetics, Genetic Counselling, Hearing Aid Acoustics, Occupational Therapy, Orthoptics, Podiatry, Speech Therapy and Private Nurse Practitioners.	Subject to Personal Savings Account. Threshold Benefit applies.
ALTERNATIVE HEALTHCARE SERVICES Only for registered: Acupuncturist, Homeopaths, Naturopaths, Osteopaths and Phytotherapists.	Subject to Personal Savings Account.

WELLNESS Benefits

Your Wellness Benefit encourages you to take charge of your health through preventative tests and procedures. At Medshield we encourage members to have the necessary tests done at least once a year.

Unless otherwise specified subject to Overall Annual Limit, thereafter subject to the Personal Savings Account, excluding consultations for the following services:

BENEFIT CATEGORY	BENEFIT LIMIT AND COMMENTS
Flu Vaccination	**1 per beneficiary 18+ years** old to a maximum of **R90**.
Pap Smear	**1 per female** beneficiary.
Bone Density (for Osteoporosis and bone fragmentation)	**1 per beneficiary 50+ years** old **every 3 years**.
Health Risk Assessment (Pharmacy or GP)	**1 per beneficiary 18+ years** old per annum.
TB Test	**1 test** per beneficiary.
National HIV Counselling Testing (HCT)	**1 test** per beneficiary.
Mammogram (Breast Screening)	**1 per female** beneficiary **40+ years** old **every 2 years**.
Pneumococcal Vaccination	**1 per annum** for high risk individuals and for beneficiaries **60+ years** old.
Birth Control (Oral Contraceptive Medication)	Restricted to **1 month's** supply to a maximum of **12 prescriptions** per annum per female beneficiary with a script limit of **R150.** Limited to the Scheme's Contraceptive formularies and protocols.
Adult Vaccinations Including Travel Vaccination	**R1 355** per family per annum.
HPV Vaccination (Human Papillomavirus)	**1 per female** beneficiary. Subject to qualifying criteria.
Child Immunisations	Immunisation programme as per the Department of Health Protocol and specific age groups.
At Birth: Tuberculosis (BCG) and Polio (OPV).	
At 6 Weeks: Polio (OPV), Diptheria, Tetanus, Whooping Cough (DTP), Hepatitis B, Hemophilus Influenza B (HIB), Rotavirus, Pneumococcal.	
At 10 Weeks: Polio, Diptheria, Tetanus, Whooping Cough (DTP), Hepatitis B, Hemophilus Influenza B (HIB), Rotavirus, Pneumococcal.	
At 14 Weeks: Polio, Diptheria, Tetanus, Whooping Cough (DTP), Hepatitis B, Hemophilus Influenza B (HIB), Pneumococcal.	
At 9 Months: Measles, Pneumococcal.	
At 18 Months: Polio, Diptheria, Tetanus, Whooping Cough (DTP), Measles OR Measles, Mumps and Rubella (MMR).	
At 6 Years: Polio, Diptheria and Tetanus (DT).	
At 12 Years: Diptheria and Tetanus (DT).	

The following tests are covered under the Health Risk Assessment

- Cholesterol
- Blood Glucose
- Blood Pressure
- Body Mass Index (BMI)

Child immunisation

Through the following providers:

- Medshield Pharmacy Network Providers
- Clicks Pharmacies
- General Practitioner Network

Health Risk Assessments

Can be obtained from:

- Medshield Pharmacy Network Providers
- Clicks Pharmacies
- General Practitioner Network
- Medshield Corporate Wellness Days

AMBULANCE Services

You and your registered dependants will have access to a 24 hour Helpline. Call Netcare 911 on 086 100 6337 (+27 10 209 8011) for members outside the borders of South Africa.

BENEFIT CATEGORY	BENEFIT LIMIT AND COMMENTS
EMERGENCY MEDICAL SERVICES Subject to pre-authorisation by Netcare 911. **Clinical Protocols apply.**	**Unlimited.**

24 Hour access to the Netcare 911 Emergency Operation Centre

Telephonic **medical** advice

Emergency medical response by road or air to scene of an emergency incident

Transfer from scene to the closest, most appropriate **facility for stabilisation and definitive care**

Medically justified transfers to special care centres or inter-facility transfers

MONTHLY Contributions

PREMIUM PLUS OPTION	PREMIUM	SAVINGS (INCLUDED IN PREMIUM)
Principal Member	**R4 830**	**R1 206**
Adult Dependant	**R4 413**	**R1 104**
Child	**R903**	**R225**

(Contribution rate is applicable to the member's first, second and third biological or legally adopted children only, excluding students)

INTERNATIONAL Travel Cover

Covers emergency medical service and pre-existing medical conditions for members traveling abroad.

BENEFIT CATEGORY	BENEFIT LIMIT AND COMMENTS
INTERNATIONAL TRAVEL COVER Subject to declaration of travel and obtaining an insurance certificate, visa letter and policy documentation from the Scheme accredited Travel Insurance Partner on (+27 11 521 4000).	**Benefits apply to valid, paid up members. Members must be fit and healthy to travel.**
• **Emergency Medical and related expenses. No excess for in-patient treatment**	**R1 million per journey** per beneficiary. **R500** excess for out-patient treatment for each claim will apply.
• **Pre-Existing Medical conditions**	**R350 000** per beneficiary per event.
Inclusive of the following: • Medical Transportation, Evacuation and Repatriation • Compassionate Emergency visits by Family • Repatriation of Travel companion • Burial, cremation or return of mortal remain • Cover is limited to **90 consecutive days** • **Top-up option** available at an additional cost	Pre-authorisation before incurring any expenses over **R10 000** will apply.
Subject to Managed Care Protocols.	

Pre-existing condition is any medical condition for which you are receiving treatment at the date of departure of your International Journey or any recurring, chronic or continuing illness or condition(s) for which you received treatment or advise or in respect of which **you** incurred any costs, during the **6 months** prior to the departure date of or your International Journey.

What is not covered by the **TRAVEL INSURANCE POLICY?**

- Pregnancy or childbirth from the 1st day of the 26th week of pregnancy
- A child born whilst on the journey
- Treatment that the medical advisors are aware will arise during the International Journey or where a medical advisor has advised against travel
- Vascular, cardiovascular or cerebrovascular conditions if the member is over the age of 69 years
- Investigatory treatment that is not specified by a medical practitioner appointed by the Insurer as immediately necessary
- Elective surgery, procedures or medical appointments

MEDSHIELD Medical Scheme Banking Details

Bank: Nedbank | Branch: Rivonia | Branch code: 196905 | Account number: 1969125969

WEBSITE

Our website is an informative, user-friendly online portal, providing you with easy access and navigation to key member related information. It features regular Scheme updates and a Wellness section which provides expert advice on maintaining a balanced lifestyle.
Visit www.medshield.co.za for more information and to register to view you're the following details:

- Membership details
- Claims status and details
- Savings balance
- Summary of used and available benefits

FRAUD

Fraud presents a significant risk to the Scheme and members. The dishonesty of a few individuals may negatively impact the Scheme and distort the principles and trust that exist between the Scheme and its stakeholders. Fraud, for practical purposes, is defined as a dishonest, unethical, irregular, or illegal act or practice which is characterised by a deliberate intent at concealment of a matter of fact, whether by words, conduct, or false representation, which may result in a financial or non-financial loss to the Scheme. Fraud prevention and control is the responsibility of all Medshield members and service providers so if you suspect someone of committing fraud, report it to us immediately.

Hotline: 080 002 0800
email: fraud@medshield.co.za

COMPLAINTS Escalation Process

In the spirit of promoting the highest level of professional and ethical conduct, Medshield Medical Scheme is committed to a complaint management approach that treats our members fairly and effectively in line with our escalation process.

In the event of a routine complaint, you may call Medshield at 086 000 2120 and request to speak to the respective Manager or the Operations Manager.

Complaints can be directed via email to complaints@medshield.co.za, which directs the complaint to the respective Manager and Operations Manager. The complaint will be dealt with in line with our complaints escalation procedure in order to ensure fair and timeous resolution.

ONLINE SERVICES - Apple iPad and Android Member Apps

It has now become even easier to manage your healthcare! Medshield members now have access to real-time, online software applications which allow members to access their member statements as well as claims information anywhere and at any time.

Aside from viewing member statements you can also use these apps for hospital pre-authorisation, to view or email your tax certificate, get immediate access to your membership details through the digital membership card on the app as well as check your claims through the claims checker functionality in real time. This service allows members to search for healthcare professionals or establishments in just a few easy steps.

The Apple Ipad App is available from iTunes and the Android version from the Playstore.

PRESCRIBED Minimum Benefits (PMB)

All members of Medshield Medical Scheme are entitled to a range of guaranteed benefits; these are known as Prescribed Minimum Benefits (PMB). The cost of treatment for a PMB condition is covered by the Scheme, provided that the services are rendered by the Scheme's Designated Service Provider (DSP) and according to the Scheme's protocols and guidelines.

What are PMBs?

The aim of PMBs is to provide medical scheme members and beneficiaries with continuous care to improve their health and well-being, and to make healthcare more affordable.

These costs are related to the diagnosis, treatment and care of the following three clusters:

CLUSTER 1

Emergency medical condition

- An emergency medical condition means the sudden and/or unexpected onset of a health condition that requires immediate medical or surgical treatment
- If no treatment is available the emergency may result in weakened bodily function, serious and lasting damage to organs, limbs or other body parts or even death

CLUSTER 2

Diagnostic Treatment Pairs (DTP)

- Defined in the DTP list on the Council for Medical Schemes' website. The Regulations to the Medical Schemes Act provide a long list of conditions identified as PMB conditions
- The list is in the form of Diagnosis and Treatment Pairs. A DTP links a specific diagnosis to a treatment and therefore broadly indicates how each of the 270 PMB conditions should be treated and covered

CLUSTER 3

26 Chronic Conditions

- The Chronic Disease List (CDL) specifies medication and treatment for these conditions
- To ensure appropriate standards of healthcare an algorithm published in the Government Gazette can be regarded as benchmarks, or minimum standards for treatment

WHY PMBs?

PMBs were created to:

- Guarantee medical scheme members and beneficiaries with continuous care for these specified diseases. This means that even if a member's benefits have run out, the medical scheme has to pay for the treatment of PMB conditions
- Ensure that healthcare is paid for by the correct parties. Medshield members with PMB conditions are entitled to specified treatments which will be covered by the Scheme

This includes treatment and medicines of any PMB condition, subject to the use of the Scheme's Designated Service Provider, treatment protocols and formularies.

WHY Designated Service Providers are important?

A Designated Service Provider (DSP) is a healthcare provider (doctor, pharmacist, hospital, etc) that is Medshield's first choice when its members need diagnosis, treatment or care for a PMB condition. If you choose not to use the DSP selected by the Scheme, you may have to pay a portion of the provider's account as a co-payment. This could either be a percentage based co-payment or the difference between the DSPs tariff and that charged by the provider you went to.

If you choose not to use the DSP selected by your scheme, you may have to pay a portion of the bill as a co-payment.

QUALIFYING to enable your claims to be paid

- One of the types of codes that appear on healthcare provider accounts is known as International Classification of Diseases ICD-10 codes. These codes are used to inform the Scheme about what conditions their members were treated for, so that claims can be settled correctly
- Understanding your PMB benefit is key to having your claims paid correctly. More details than merely an ICD-10 code are required to claim for a PMB condition and ICD-10 codes are just one example of the deciding factors whether a condition is a PMB
- In some instances you will be required to submit additional information to the Scheme. When you join a medical scheme or in your current option, you choose a particular set of benefits and pay for this set of benefits. Your benefit option contains a basket of services that often has limits on the health services that will be paid for
- Because ICD-10 codes provide information on the condition you have been diagnosed with, these codes, along with other relevant information required by the Scheme, help the Scheme to determine what benefits you are entitled to and how these benefits should be paid
- The Scheme does not automatically pay PMB claims at cost as, in its experience there is a possibility of over-servicing members with PMB conditions. It therefore remains your responsibility, as the member, to contact the Scheme and confirm PMB treatments provided to you

If your PMB claim is rejected you can contact Medshield on 086 000 2120 (+27 10 597 4701) to query the rejection.

YOUR RESPONSIBILITY as a member

EDUCATE yourself about:

- The Scheme Rules
- The listed medication
- The treatments and formularies for your condition
- The Medshield Designated Service Providers (DSP)

RESEARCH your condition

- Do research on your condition
- What treatments and medications are available?
- Are there differences between the branded drug and the generic version for the treatment of your condition?

DON'T bypass the system

- If you must use a GP to refer you to a specialist, then do so.
- Make use of the Scheme's DSPs as far as possible.
- Stick with the Scheme's listed drugs for your medication

TALK to us!

- Ask questions and discuss your queries with Medshield.
- Make sure your doctor submits a complete account to Medshield.

CHECK that your account was paid

- Follow up and check that your account is submitted within four months and paid within 30 days after the claim was received (accounts older than four months are not paid by medical schemes)

IMPORTANT to note

When diagnosing whether a condition is a PMB, the doctor should look at the signs and symptoms at point of consultation. This approach is called a diagnosis-based approach.

- Once the diagnosis has been made, the appropriate treatment and care is decided upon as well as where the patient should receive the treatment i.e. at a hospital, as an outpatient ,or at a doctor's rooms
- Only the final diagnosis will determine if the condition is a PMB or not
- Any unlimited benefit is strictly paid in accordance with PMB guidelines and where treatment is in line with prevailing public practice

HEALTHCARE PROVIDERS' responsibilities

Doctors do not usually have a direct contractual relationship with medical schemes. They merely submit their accounts and if the Scheme does not pay, for whatever reason, the doctor turns to the member for the amount due. This does not mean that PMBs are not important to healthcare providers or that they don't have a role to play in its successful functioning. Doctors should familiarise themselves with ICD-10 codes and how they correspond with PMB codes and inform their patients to discuss their benefits with their scheme, to enjoy guaranteed cover.

How to avoid rejected PMB claims?

- Ensure that your doctor (or any other healthcare service provider) has quoted the correct ICD-10 code on your account. ICD-10 codes provide accurate information on your diagnosis
- ICD-10 codes must also be provided on medicine prescriptions and referral notes to other healthcare providers (e.g. pathologists and radiologists)
- The ICD-10 code must be an exact match to the initial diagnosis when your treating provider first diagnosed your chronic condition or it will not link correctly to pay from the PMB benefit
- When you are registered for a chronic condition and you go to your treating doctor for your annual check-up, the account must reflect the correct ICD-10 code on the system. Once a guideline is triggered a letter will be sent to you with all the tariff codes indicating what will be covered from PMB benefits
- Only claims with the PMB matching ICD-10 code and tariff codes will be paid from your PMB benefits. If it does not match, it will link to your other benefits, if available
- Your treatment must be in line with the Medshield protocols and guidelines

PMB CARE templates

The law requires the Scheme to establish sound clinical guidelines to treat ailments and conditions that fall under PMB regulation. **These are known as ambulatory PMB Care templates**.

The treatment protocol is formulated into a treatment plan that illustrates the available number of visits, pathology and radiology services as well as other services that you are entitled to, under the PMB framework.

TREATMENT Plans

Treatment Plans are formulated according to the severity of your condition. In order to add certain benefits onto your condition, your Doctor can submit a clinical motivation to our medical management team.

When you register on a Managed Care Programme for a PMB condition, the Scheme will provide you with a Treatment Plan.

When you register for a PMB condition, ask for more information on the Treatment Plan set up for you.

The treatment protocol for each condition may include the following:

- The type of consultations, procedures and investigations which should be covered
- These will be linked to the condition's ICD-10 code(s)
- The number of procedures and consultations that will be allowed for a PMB condition can be limited per condition for a patient

The frequency with which these procedures and consultations are claimed can also be managed.

Addendum **A**

INFERTILITY INTERVENTIONS AND INVESTIGATIONS

Limited to interventions and investigations as prescribed by the Regulations to the Medical Schemes Act 131 of 1998 in Addendum A paragraph 9, code 902M. This benefit will include the following procedures and interventions:

Hysterosalpinogram	Rubella
Laparoscopy	HIV
Hysteroscopy	VDRL
Surgery (uterus and tubal)	Chlamydia
Manipulation of the ovulation defects and deficiencies	Day 21 Progesteron
Semen analysis (volume, count, mobility, morphology, MAR-test)	Basic counselling and advice on sexual behaviour
Day 3 FSH/LH	Temperature charts
Oestradoil	Treatment of local infections
Thyroid function (TSH)	Prolactin

Addendum **B**

PROCEDURES AND TESTS IN PRACTITIONERS' ROOMS

Breast fine needle biopsy	Prostate needle biopsy
Vasectomy	Circumcision
Excision Pterygium with or without graft	Excision wedge ingrown toenail skin of nail fold
Excision ganglion wrist	Drainage skin abscess/curbuncle/whitlow/cyst
Excision of non-malignant lesions less than 2cm	

ROUTINE DIAGNOSTIC ENDOSCOPIC PROCEDURES

Hysteroscopy	Oesophageal motility studies
Upper and lower gastro-intestinal fibre-optic endoscopy	Fibre-optic Colonoscopy
24 hour oesophageal PH studies	Sigmoidoscopy
Cystoscopy	Urethroscopy
Colposcopy (excluding after-care)	Oesophageal Fluoroscopy

MEDSHIELD
medical scheme

DISCLAIMER

This brochure acts as a summary and does not supersede the Registered Rules of the Scheme.
All benefits in accordance with the Registered Rules of the Scheme.
Terms and conditions of membership apply as per Scheme Rules.
September 2017