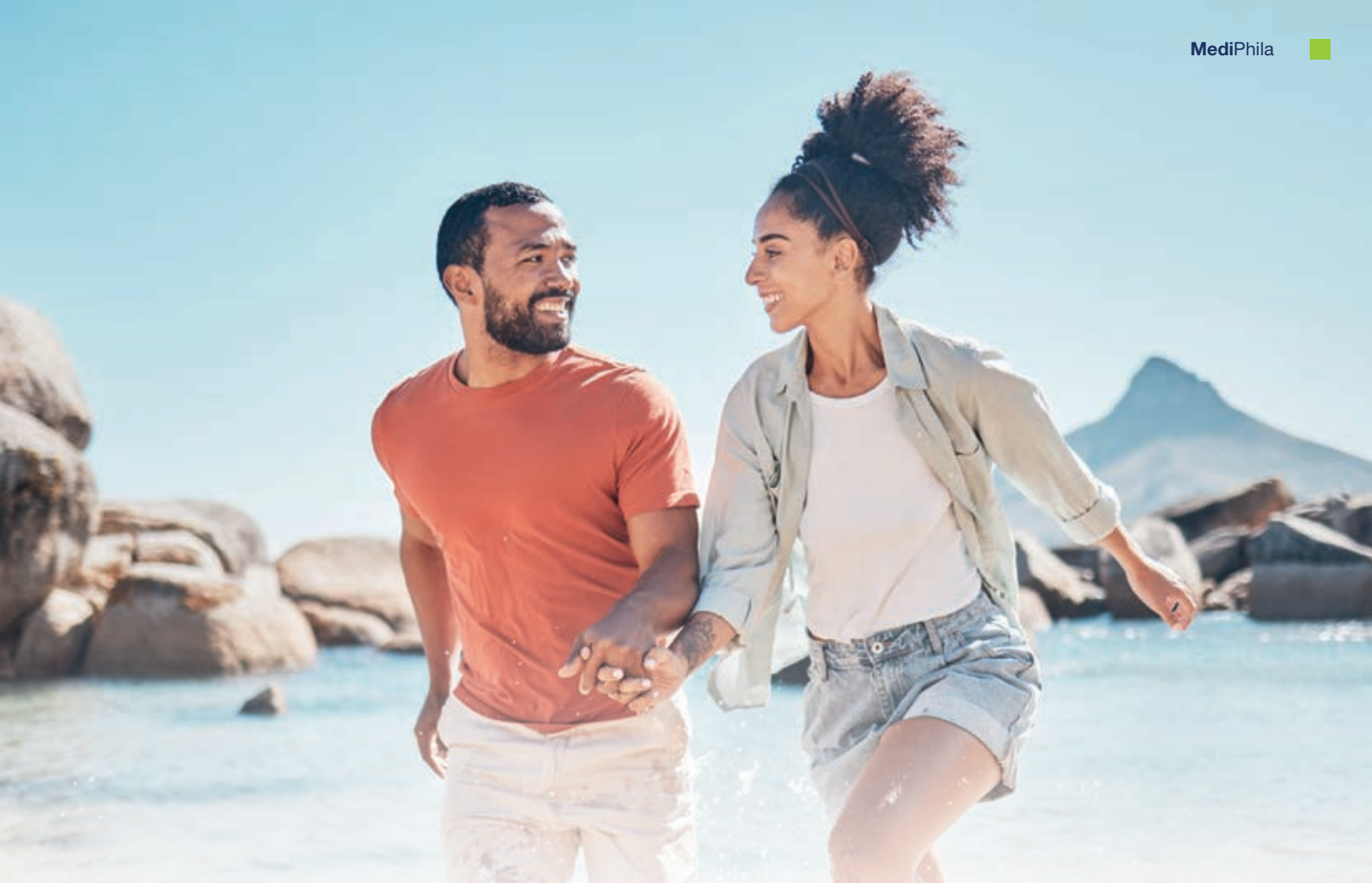
MediPhila

2025 Benefit Guide

MEDSHIELD
medical scheme
Partner for Life

Contents



MediPhila Benefit Option

MediPhila is ideal for families seeking first-time access to affordable private medical cover.
As a MediPhila member, you have full cover for Prescribed Minimum Benefit (PMB) treatment plus R1 million per family for non-PMB In-Hospital treatment in the MediPhila Hospital Network. Coupled with this is Day-to-Day cover for your essential daily healthcare needs.

This is an overview of the benefit categories on the **MediPhila** option.

Major Medical Benefits (In-Hospital)	Out-of-Hospital Benefits	Maternity Benefits	Wellness Benefits	Chronic Medicine	Oncology Benefits

Monthly Contributions

MEDIPHILA OPTION	PREMIUM
Principal Member	R2 004
Adult Dependant	R2 004
Child	R519

DEFINITION: *Adult Dependant: A dependant who is 21 years or older, excluding a student up to age of 28 years (as per the Scheme Rules).*
Child Dependant: A dependant under the age of 21 years, including a student (as per the Scheme Rules) under the age of 28.

The Application of Co-payments

The following services will attract upfront co-payments:

Voluntary consultation with a Medical Specialist without a referral from a MediPhila Network GP	**20% upfront co-payment**
Voluntarily obtained out of formulary medication	**25% upfront co-payment**
Voluntary use of a non-Compact Network Hospital	**30% upfront co-payment**
Voluntary use of a non-Compact Network Hospital Organ, Tissue and Haemopoietic stem cell (Bone marrow) transplant	**30% upfront co-payment**
Voluntary use of a non-DSP for Chronic Medication	**30% upfront co-payment**
Voluntary use of a non-DSP for HIV & AIDS related medication	**30% upfront co-payment**
Voluntary use of a non-Specialist Network provider	**30% upfront co-payment**
Voluntary use of non-Compact Network Hospital for Mental Health admissions	**30% upfront co-payment**
Voluntary use of a non-DSP provider - Chronic Renal Dialysis	**35% upfront co-payment**
Non-Network Emergency GP consultations (once the two allocated visits have been depleted)	**40% upfront co-payment**
Voluntary use of a non-ICON provider - Oncology	**40% upfront co-payment**

In-Hospital and Day Clinic Procedural upfront co-payments for non-PMB	
Wisdom Teeth extraction in a Day Clinic	**R1 800 upfront co-payment**
Impacted Teeth, Wisdom Teeth and Apicectomy	**R4 000 upfront co-payment**
Hysterectomy	**R5 000 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***, in addition to the above co-payments.*
**No In-Hospital Endoscopic procedural co-payment applicable for children 8 years and younger.*

Your Guide to Access your MediPhila In-Hospital Benefit

Before you or any of your registered dependants are admitted to hospital, it is important that you know which hospitals form part of the MediPhila Hospital Network to obtain hospital pre-authorisation. If you are hospitalised, your stay will be subject to the period that was pre-authorised by the Hospital Benefit Management. No further benefits will be paid unless such a stay is further authorised. Hospital pre-authorisation can be initiated by the member, medical practitioner or the hospital at least 72-hours before admission, or the first working day following an emergency admission.

What is hospital pre-authorisation?

Every member has to obtain pre-approval or pre-authorisation from the Scheme before the member, or their dependants, are admitted to hospital. The Scheme will provide pre-authorisation, upon your request, in line with the benefits available for the specific procedure or treatment, prior to admission. The pre-authorisation process ensures added value for both the member and the Scheme by assessing the medical necessity and appropriateness of the procedure prior to hospital admission according to clinical protocols and guidelines.

The following information is required when requesting pre-authorisation for hospitalisation:

- Membership number
- Member or beneficiary name and date of birth
- Contact details
- Reason for admission
- ICD-10 codes and relevant procedure (tariff codes)
- Date of admission and date of the operation if applicable
- Proposed length of stay
- Name and practice number of the admitting doctor
- Name and practice number of the hospital

Which hospital am I allowed to use?

Compact Hospital Network. Please contact the Scheme on 086 000 0376 (+27 10 597 4703) or vist www.medshield.co.za to access a list of hospitals.

Why it's important to pre-authorise?

- Your hospital stay will be subject to the procedure or service pre-authorised by the Hospital Management partner
- Any additional days or multiple procedures or additional services will require further pre-authorisation or motivation

In the case of an emergency admission, retrospective authorisation must be obtained on the first working day following an emergency admission. Should a member fail to obtain pre-authorisation, the Scheme will not settle any claims related to the admission.

What if my hospital admission is postponed or I'm re-admitted, even if I have pre-authorisation?

You will have to update your pre-authorisation with Medshield Hospital Benefit Management with the relevant date before you are admitted. If you are re-admitted for the same condition you will have to obtain a new authorisation as authorisations are event driven.

What is an emergency?

It is not enough for a medical emergency to be diagnosed only. The Council for Medical Schemes (CMS) script on what an emergency is, states that a condition is an emergency if you require immediate treatment for serious impairment to bodily function.

"All medical emergencies are prescribed minimum benefits (PMBs) which require full payment from your medical scheme. But diagnosis alone is not enough to conclude that a condition is a medical emergency. The condition must require immediate treatment before it can qualify as an emergency and, subsequently, a PMB."

So when is a medical condition an emergency?

The Medical Schemes Act 131 of 1998 defines an "emergency medical condition" as "the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a body organ or part, or would place the person's life in serious jeopardy".

Put simply, the following factors must be present before an emergency can be concluded:

- There must be an onset of a health condition
- This onset must be sudden and unexpected
- The health condition must require immediate treatment (medical or surgical)
- If not immediately treated, one of three things could result: serious impairment to a bodily function, serious dysfunction of a body part or organ, or death
- If you are not treated for your condition and only tests are conducted, your medical scheme does not necessarily need to cover your condition because tests are diagnostic measures which are not covered by the definition of an emergency. If you are treated, you can claim the cost of treatment because it cannot reasonably be argued that a health condition is an emergency only if the diagnosis is confirmed

Is pre-authorisation required even if I use a hospital within the MediPhila Hospital Network?

Yes, all hospital admissions require pre-authorisation before admission and retrospective authorisation is required for emergencies. All hospital authorisations must be done through the Medshield Hospital Benefit Management Provider on 086 000 0376.

Out-of-Hospital Benefits

The Out-of-Hospital Benefit covers services obtained Out-of-Hospital. These services will be paid from your Out-of-Hospital limit, unless specified otherwise. Your Family Practitioner (FP) Limit is allocated according to your family size, and subject to the nominated Family Practitioner each beneficiary nominates one Family Practitioner, selected from the MediPhila Family Practitioner Network, to a maximum of two Family Practitioners per family. Through a partnership with various service providers, the Scheme is able to ensure that you receive optimal care for these essential Out-of-Hospital services.

What services are covered under the Out-of-Hospital Benefits?

The following services are covered from specific sub-limits:

- Family Practitioner visits – Covered from the FP benefit limit
- Acute Medicine – Covered from the Acute Medicine Benefit
- Specialist Visits – Covered from the Specialist visit benefit

- Casualty or Emergency visits – Covered from the Day-to-Day Limit, unless authorised as an emergency
- Basic Dental services – Covered from the Basic Dentistry Limit
- Optical Services – Covered from the Optical Benefit
- Radiology and Pathology – Subject to Formularies

Family Practitioner Visits

Each beneficiary is required to use a MediPhila Network Family Practitioner (FP). The Scheme has a list of all the providers that are part of the Network. This MediPhila Network Provider list is available on the website www.medshield.co.za or from the MediPhila Contact Centre.

You have access to the allocated number of Family Practitioner (FP) visits that are indicated in this benefit guide without needing pre-authorisation. Once you reach the allocated number of visits, you will need pre-authorisation to access the unlimited benefits. This can be done by having your FP contact the MediPhila Contact Centre (086 000 0376) to obtain authorisation for each and every additional visit. These additional consultations are subject to Scheme Rules, protocols and prior approval.

Out-of-Network Family Practitioner Visits

The Scheme Rules allow for up to two visits per family paid from the Overall Annual Limit. A list of all FPs contracted on the MediPhila Network is available on the Scheme website or you can contact the Medshield Contact Centre to enquire about a FP in the area where you find yourself. Please note that the unlimited FP benefit does not apply to out-of-network visits.

Minor Procedures while visiting the FP

Certain minor procedures done in the FP consultation room will be paid from the Overall Annual Limit if done by a Network FP; these include stitching of wounds, limb casts, removal of foreign bodies and excision, repair and drainage of a subcutaneous abscess, and the removal of a nail. If these services are performed by a non-Network Provider these costs will be covered from your Day-to-Day Limit. Refer to Addendum C for a full list of services.

Casualty and Emergency Room Cover

Should you or your family have to go to a casualty or emergency room at a hospital due to medical necessity, the account for the Casualty will be paid from your available Day-to-Day Limit and the doctor attending to you will be paid from your out of network FP benefit.

Acute Medication

The MediPhila option offers members a separate Acute Medication limit subject to the Acute Medication formulary. If medication is dispensed from your FP, this cost will be included in your FP consultation but should it be required that you get your medication from a MediPhila Network Pharmacy, this cost will come from your Acute Medication Benefit. It is important that you make your FP/Pharmacy aware that your option has an acute formulary as any medication not on the formulary will not be covered. Schedule 1 and 2 medications offered as Pharmacy Advised Therapy (PAT) will be covered from your Acute Medication Benefit subject to a **R500** script limit and 1 script per beneficary per day.

Reference pricing is applied. If a product is prescribed that is more expensive than the reference price, the patient will need to pay the difference in price at the point of dispensing.

- Quantity limits may apply to some items on this formulary. Quantities in excess of this limit will need to be funded by the member at the point of dispensing, unless an authorisation has been obtained for a greater quantity
- Other generic products not specifically listed will be reimbursed in full if the price falls within the reference price range for that group
- The formulary is subject to regular review. Medshield reserves the right to update and change the formulary when new information becomes available, prices change, or when new medicines are released
- What happens once you have reached your Day-to-Day Limit?
  - The services that are covered under your Day-to-Day Limit offers a pre-determined sub-limit. Once these sub-limits have been reached, members will be required to cover the cost out of pocket

Access to Basic Dental Services

The benefit includes primary dentist care e.g. consultations, fillings, scaling and polishing, and must be obtained from the MediPhila Dental Network. There is no benefit for Specialised Dentistry like root canal treatment, crowns and metal base dentures.

Medical Specialist Consultations

For Medical Specialist Consultations you have to be referred by a MediPhila Network FP Provider:

- The MediPhila Network Family Practitioner (FP) Provider is required to obtain a Specialist referral authorisation from the Scheme;
- It is important to note that you will be liable for a 40% co-payment for Medical Specialists' Consultations obtained outside these stipulated guidelines.

Access to Pathology and Radiology Services

The MediPhila FP Provider will refer you to the appropriate pathology and radiology healthcare provider.

- Radiology and Pathology formularies apply as per managed care protocols;
- All tests that falls within the formularies will be paid from the Overall Annual Limit in line with managed care protocols; and
- Any additional pathology and radiology tests that falls within PMB level of care will need to be motivated by a MediPhila FP.

Access to Optical Services

Spectacles, frames and lenses are covered at **R1 500** per beneficiary over a 24 month Optical Service Cycle and must be obtained from the Scheme's preferred provider. Kindly note that any additional services such as tinting etc. are not covered under this benefit. You will have to pay for these services yourself. Eye tests are limited to one test per beneficiary every 24 months. The Optical Benefit is available per beneficiary, over a 24 month Optical Service date cycle.

Major Medical Benefits: In-Hospital

BENEFIT CATEGORY	BENEFIT LIMITS AND COMMENTS
OVERALL ANNUAL LIMIT	• **Unlimited**.
HOSPITAL NETWORK	• Compact Hospital Network.
HOSPITAL LIMIT	• **R1 000 000** per family for non-PMB conditions.
• **Hospital co-payment for non-network hospital**	• **30% upfront co-payment** for the use of non-Compact Network Hospital.
SURGICAL PROCEDURES As part of an authorised event.	• Subject to the Hospitalisation Limit.
MEDICINE ON DISCHARGE FROM HOSPITAL Included in the Hospital benefit if detailed on the hospital account or if obtained from a Pharmacy on the day of discharge. • According to the Maximum Generic Pricing or Medicine Price List and Formularies.	• **R500** per admission.
ALTERNATIVES TO HOSPITALISATION Pre-authorisation is required. Treatment only available immediately following an event. Includes Physical Rehabilitation, Sub-Acute Facilities, Nursing Services and Hospice. *Clinical Protocols apply.*	• PMB and PMB level of care. • **30% upfront co-payment** for the use of a non-network facility.
• **Terminal Care Benefit** *Clinical Protocols apply.*	• **R36 700** per family per annum. • PMB and PMB Level of care.
GENERAL, MEDICAL AND SURGICAL APPLIANCES Service must be pre-approved and obtained from the DSP Network Provider or Preferred Provider.	• No Benefit.
Hiring or buying of Appliances, External Accessories and Orthotics:	
• **Peak Flow Meters, Nebulizers, Glucometers and Blood Pressure Monitors** (motivation required)	• No Benefit.
• **Hearing Aids** (Including repairs) Prior Scheme approval required 4 Year Clinical Protocol apply.	• No Benefit.
• **Wheelchairs** (including repairs) Prior Scheme approval required.	• No Benefit.
• **Stoma Products and Incontinence Sheets related to Stoma Therapy** Pre-authorisation is required.	• PMB and PMB level of care.
• **CPAP Apparatus for Sleep Apnoea** Pre-authorisation is required and services must be obtained from the Preferred Provider. *Clinical Protocols apply.*	• PMB and PMB level of care.
OXYGEN THERAPY EQUIPMENT Pre-authorisation is required and services must be obtained from the DSP or Network Provider. *Clinical Protocols apply.*	• PMB and PMB level of care.
HOME VENTILATORS Pre-authorisation is required and services must be obtained from the DSP or Network Provider. *Clinical Protocols apply.*	• PMB and PMB level of care.
BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS (Including emergency transportation of blood) Pre-authorisation is required and services must be obtained from the DSP or Network Provider. *Clinical Protocols apply.*	• PMB and PMB level of care.

Major Medical Benefits: In-Hospital

BENEFIT CATEGORY	BENEFIT LIMITS AND COMMENTS
MEDICAL PRACTITIONER CONSULTATIONS AND VISITS As part of an authorised event during hospital admission, including Medical and Dental Specialists or General Practitioners.	• Subject to the Hospitalisation Limit.
SLEEP STUDIES Pre-authorisation is required. Includes: Diagnostic Polysomnograms and CPAP Titration. *Clinical Protocols apply.*	• No Benefit.
ORGAN TISSUE AND HAEMOPOIETIC STEM CELL (BONE MARROW) TRANSPLANTATION Pre-authorisation is required. Includes the following: Immuno-Suppressive Medication, Post Transplantation and Biopsies and Scans, Related Radiology and Pathology *Clinical Protocols apply.*	• PMB and PMB level of care. • **30% upfront co-payment** for the use of a non-Compact Network Hospital. • Organ harvesting is limited to the Republic of South Africa. • Work-up costs for donor in Solid Organ Transplants included. • No benefit 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.
• **Corneal Grafts** (Internationally sourced Cornea).	• **R51 900** per beneficiary.
• **Corneal Grafts** (Locally sourced Cornea).	• **R22 250** per beneficiary.
PATHOLOGY AND MEDICAL TECHNOLOGY As part of an authorised event and excludes allergy and vitamin D testing. *Clinical Protocols apply.*	• Subject to the Hospitalisation Limit.
PHYSIOTHERAPY In-Hospital Physiotherapy requires pre-authorisation. In lieu of hospitalisation also refer to 'Alternatives to Hospitalisation' in this guide.	• **R3 300** per beneficiary per annum, subject to the Hospitalisation Limit. • Thereafter subject to the Day-to-Day Limit unless specifically pre-authorised for PMB and PMB level of care.
PROSTHESIS AND DEVICES INTERNAL Pre-authorisation is required for surgically implanted devices. Preferred Provider Network applies. *Clinical Protocols apply.*	• PMB and PMB level of care for all joint procedures.
PROSTHESIS EXTERNAL Pre-authorisation is required. Preferred Provider Network applies. Including Ocular Prosthesis. *Clinical Protocols apply.*	• PMB and PMB level of care.
LONG LEG CALLIPERS Pre-authorisation is required and service must be obtained from the DSP, Network Provider or Preferred Provider.	• PMB and PMB level of care.
GENERAL RADIOLOGY As part of an authorised event. *Clinical Protocols apply.*	• Subject to the Hospitalisation Limit.
SPECIALISED RADIOLOGY Pre-authorisation is required, and services must be obtained from the DSP or Network Provider. Includes CT Colonography (Virtual Colonoscopy). *Clinical Protocols apply.* **Includes the following:**	• **R8 250** per family per annum, In- and Out-of-Hospital. • Subject to the Hospitalisation Limit.
• CT scans, MUGA scans, MRI scans, Radio Isotope studies.	• Subject to the Specialised Radiology Limit.
• Interventional Radiology replacing Surgical Procedures.	• PMB only.

BENEFIT CATEGORY	BENEFIT LIMITS AND COMMENTS
CHRONIC RENAL DIALYSIS Pre-authorisation is required, and services must be obtained from the DSP for PMB and non-PMB. Haemodialysis and Peritoneal Dialysis include the following: Material, Medication, related Radiology and Pathology. *Clinical Protocols apply.*	• PMB and PMB level of care. • **35% upfront co-payment** for the use of a non-DSP.
NON-SURGICAL PROCEDURES AND TESTS As part of an authorised event. The use of the Medshield Specialist Network applies.	• Subject to the Hospitalisation Limit.
MENTAL HEALTH Pre-authorisation is required. The use of the Medshield Specialist Network applies. Up to a maximum of 3 days if patient is admitted by a General Practitioner.	• PMB and PMB level of care. • **30% upfront co-payment** for the use of a non-Compact Network Hospital. • DSP applicable from Rand one.
• **Rehabilitation for Substance Abuse** 1 rehabilitation programme per beneficiary per annum	• PMB and PMB level of care.
• **Consultations and Visits, Procedures, Assessments, Therapy, Treatment and/or Counselling**	• PMB and PMB level of care.
HIV & AIDS Pre-authorisation is required and treatment must be obtained from the DSP. **Includes the following:**	• As per Managed Healthcare Protocols.
• Anti-retroviral and related medicines. • HIV/AIDS related Pathology and Consultations. • National HIV Counselling and Testing (HCT).	• **30% upfront co-payment** for out-of-formulary PMB medication voluntarily obtained or PMB medication voluntarily obtained from a provider other than the DSP.
INFERTILITY INTERVENTIONS AND INVESTIGATIONS Pre-authorisation is required and services must be obtained from the DSP. Use of the Medshield Specialist Network applies. *Clinical Protocols apply.*	• Limited to interventions and investigations only. • ***Refer to Addendum A*** for list of procedures and blood tests.

Maternity Benefits

Benefits will be offered during pregnancy, at birth and after birth. Pre-authorisation is required.
A Medshield complimentary baby bag can be requested during the 3rd trimester. Kindly send your request to medshieldmom@medshield.co.za.

BENEFIT CATEGORY	BENEFIT LIMITS AND COMMENTS
ANTENATAL CONSULTATIONS The use of the Medshield Specialist Network applies.	• **6** Antenatal consultations per pregnancy.
ANTENATAL CLASSES & POSTNATAL MIDWIFE CONSULTATIONS	• **4** Visits per event.
PREGNANCY RELATED SCANS AND TESTS	• **Two** 2D scans per pregnancy.
CONFINEMENT Pre-authorisation is required and services must be obtained from a DSP and relevant Provider Network. The use of the Medshield Specialist Network applies. *Clinical Protocols apply.*	
• **Confinement In-Hospital**	• **Unlimited**, with the use of a Compact Network Hospital. • **30% upfront co-payment** applies for the voluntary use of a non-Compact Network Hospital.
• **Delivery by a General Practitioner or Medical Specialist**	• **Unlimited**.
• **Confinement in a registered birthing unit or Out-of-Hospital**	• **Unlimited**.
• **Delivery by a registered Midwife/Nurse or a Practitioner**	• **Unlimited**.
• **Hire of water bath and oxygen cylinder**	• **Unlimited**.

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 LIMITS AND COMMENTS
ONCOLOGY LIMIT The use of non-DSP will attract a **40% upfront co-payment**.	• PMB and PMB level of care.
• **Active Treatment** (Chemotherapy and Radiotherapy)	• Subject to the Oncology Limit. • ICON **Essential** Protocols apply.
• **Oncology Medicine**	• Subject to the Oncology Limit. • ICON **Essential** Protocols apply.

BENEFIT CATEGORY	BENEFIT LIMITS AND COMMENTS
• **Radiology and Pathology** Only Oncology related Radiology and Pathology as part of an authorised event.	• PMB and PMB level of care.
• **PET and PET-CT SCANS**	• PMB and PMB level of care. • **1 scan** per family per annum.
INTEGRATED CONTINUOUS CANCER CARE Social worker psychological support during cancer care treatment.	• **4 visits** per family per annum. • Subject to the Oncology Limit.
SPECIALISED DRUGS FOR ONCOLOGY, NON-ONCOLOGY AND BIOLOGICAL DRUGS Pre-authorisation is required.	• Subject to the Oncology Medicine Limit.
• **Vitreoretinal Benefit** Pre-authorisation is required for Vitreous and Retinal disorders. *Clinical Protocols apply.*	• **R23 500** per family per annum.

Chronic Medicine Benefits

BENEFIT CATEGORY	BENEFIT LIMITS AND COMMENTS
PHARMACY NETWORK	• Pharmacy Direct, Clicks Retail Pharmacies, Clicks Direct Medicine. • Covers medicine for all 26 PMB CDL's and an additional condition.
CHRONIC MEDICINE Registration and authorisaion on the Chronic Medicine Management programme applies. The use of a Medshield Pharmacy Network Provider is applicable from Rand one. Supply of medication is limited to one month in advance.	• PMB only. • Medshield Formulary is applicable. • **25% upfront co-payment** for the use of non-formulary medicine and a **30% upfront co-payment** for the use of a non-DSP.

MEDIPHILA CHRONIC DISEASE LIST

Addison's disease
Asthma
Bi-Polar Mood Disorder
Bronchiectasis
Cardiac failure
Cardiomyopathy
Chronic renal disease
Chronic obstructive pulmonary disease
Coronary artery disease
Crohn's disease
Diabetes insipidus
Diabetes mellitus type 1
Diabetes mellitus type 2
Dysrhythmias
Epilepsy
Glaucoma
Haemophilia
Hyperlipidaemia
Hypertension
Hypothyroidism
Multiple sclerosis
Parkinson's disease
Rheumatoid arthritis
Schizophrenia
Systemic lupus erythematosus
Ulcerative colitis
Depression

Dentistry Benefits

BENEFIT CATEGORY	BENEFIT LIMITS AND COMMENTS
BASIC DENTISTRY • **Out-of-Hospital** Medshield Dental Network and Dental Protocols apply. Plastic dentures requires pre-authorisation. Failure to obtain pre-authorisation will attract a **20% penalty**.	• **R1 800** per family per annum. • Subject to the Specialised Dentistry Limit.
SPECIALISED DENTISTRY Pre-authorisation is required for all services stated below. Failure to obtain an authorisation prior to treatment will attract a **20% penalty**. Medshield Dental Network and Dental Protocols apply.	• **R7 300** per family per annum.
• **Impacted Teeth, Wisdom Teeth and Apicectomy** – Hospitalisation, general anaesthetics or conscious analgo sedation only for bony impactions. – Out-of-Hospital apicectomy of any permanent teeth only covered in Practitioners' Rooms Pre-authorisation is required. – Pre-authorisation is required for general anaesthetic and conscious analgo sedation, In- and Out-of-Hospital. – No authorisation required for apicectomy, removal of impacted teeth or wisdom teeth if done under local anaesthetics analgo sedation, Out-of-Hospital.	• Subject to the Specialised Dentistry Limit. • **R1 800 upfront co-payment** applies for wisdom teeth extraction performed in a Day Clinic. • **R4 000 upfront co-payment** applies if the procedure is done In-Hospital. (No co-payment if procedure is done under consious sedation in the Practitioners' rooms). • Pre-authorisation is required for all services. Failure to obtain an authorisation prior to treatment will attract a **20% penalty.**
• **Dental Implants** Includes all services related to Implants. Pre-authorisation is required. Medshield Dental Network and Dental Protocols apply.	• No Benefit.
• **Orthodontic Treatment** Pre-authorisation is required. Medshield Dental Network and Dental Protocols apply.	• No Benefit.
• **Crowns, Bridges, Inlays, Mounted Study Models, Partial Metal Base Dentures and Periodontics** Consultations, Visits and Treatment for all such dentistry including the Technicians' fees. Pre-authorisation is required. Medshield Dental Network and Dental Protocols apply.	• No Benefit.
MAXILLO-FACIAL AND ORAL SURGERY Pre-authorisation is required. Non-elective surgery only. Medshield Dental Network and Dental Protocols apply.	• PMB only.

SmartCare Benefits

BENEFIT CATEGORY	BENEFIT LIMITS AND COMMENTS
PHARMACY/CLINIC PRIVATE NURSE PRACTITIONER CONSULTATIONS The use of the SmartCare Pharmacy Network is compulsory from Rand one.	• **Unlimited**.
NURSE-LED VIRTUAL GENERAL PRACTITIONER (GP) CONSULTATIONS Subject to the use of the SmartCare General Practitioner (GP) Network.	• **1** visit per family subject to the Overall Annual Limit. • Thereafter subject to the GP Consultations and Visits Limit.

Day-To-Day Benefits

This benefit provides for Out-of-Hospital day-to-day medical expenses such as General Practitioner (GP) Consultations, Specialist Consultations, Acute Medication and optical cover from your Day-to-Day Limit.

BENEFIT CATEGORY	BENEFIT LIMITS AND COMMENTS
DAY-TO-DAY LIMIT	• **R4 500** per family per annum.
GENERAL PRACTITIONER (GP) CONSULTATIONS AND VISITS: OUT-OF-HOSPITAL GP consultations and visits can be accessed in-person, telephonically or virtually. Use of the relevant General Practitioner Network applies.	• Each beneficiary **must** nominate a maximum of one General Practitioners from the MediPhila GP Network. MediPhila GP Network applies from Rand one. • Access to the following without pre-authorisation: M0 = 8 visits M+1 = 9 visits M2+ = 11 visits • Thereafter unlimited if pre-authorised.
NON-NOMINATED GENERAL PRACTITIONER CONSULTATION When you have not consulted your nominated GP.	• **2 visits** per family per annum to a MediPhila GP Network provider. • Thereafter subject to the amount of GP visits stated above. • Once these are exhausted, a **40% upfront co-payment** will apply.
MEDICAL SPECIALIST CONSULTATIONS AND VISITS The use of the Medshield Specialist Network applies. No GP referral will attract a **20% upfront co-payment** and the use of a non-network Specialist will attract a **30% upfront co-payment**.	• **1 visit** per family subject to the Day-to-Day Limit and a referral authorisation from the nominated Network GP.
CASUALTY/EMERGENCY VISITS Facility fee, Consultations and Medicine. If retrospective authorisation for emergency is obtained from the relevant Managed Healthcare Programme within 72 hours, benefit will be subject to the Overall Annual Limit. Only bona fide emergencies will be authorised.	• **2** Facility visits, thereafter subject to the Day-to-Day Limit. • Consultations subject to the General Practitioner Consultations and Visits Limit. • Medicine limited to the Acute Medicine Limit and the Day-to-Day Limit.
MEDICINES AND INJECTION MATERIAL • **Acute medicine** Service must be provided by nominated GP. Medshield medicine pricing and formularies and the relevant Pharmacy Network applies.	M+0 = **R1 750** M+1 = **R2 450** M2+ = **R2 800** • The use of Medshield Pharmacy Network applies from Rand one.
• **Pharmacy Advised Therapy** Schedules 0, 1 and 2 medicine dispensed by a Pharmacist over the counter. Medshield Formularies apply.	• **R500** per script. • **1 script** per beneficiary per day. • Subject to the Acute Medication Limit.
OPTICAL BENEFIT Optometry Programme and Protocols and Optical Network applies. 24 month Optical Service Cycle applies.	• **1 pair** of Optical Lenses and a frame limited to **R1 500** per beneficiary every 24 months. • The use of a Medshield Network Provider applies.
• **Optometric refraction** (eye test)	• **1 test** per beneficiary per 24 month Optical Service Cycle.

Day-To-Day Benefits

BENEFIT CATEGORY	BENEFIT LIMITS AND COMMENTS
• **Spectacle Lenses**	• Single vision and a Frame only. (excludes Bi-focal Lenses, Multifocal Lenses, Contact Lenses and any Lens Add-ons). • Subject to the Optical Limit.
• **Frames and/or Lens Enhancements**	• Subject to the Optical Limit.
• **Readers** If supplied by a registered Optometrist, Ophthalmologist, Supplementary Optical Practitioner or a Registered Pharmacy.	• **R210** per beneficiary per annum.
PATHOLOGY AND MEDICAL TECHNOLOGY Subject to the relevant Protocols.	• Subject to the Medshield MediPhila Basic Pathology formulary, non-formulary tests subject to PMB level of care. • Only on referral from a Network GP.
GENERAL RADIOLOGY Subject to the relevant Radiology Protocols.	• Subject to the Medshield MediPhila Basic Radiology formulary. • Only on referral from a Network GP.
SPECIALISED RADIOLOGY Pre-authorisation is required. Includes CT Scans, MUGA scans, Radio Isotope studies, CT Colonography, Interventional Radiology.	• **R8 250** per family, In- and Out-of-Hospital.
NON-SURGICAL PROCEDURES AND TESTS As part of an authorised event. The use of the Medshield Specialist Network applies.	• GP Network - subject to the Hospitalisation Limit. • Non-GP Network - subject to the Day-to-Day Limit. • Test & Procedures not specified - No Benefit. • ***Refer to Addendum C*** for a list of services.
• **Non-surgical Procedures and Tests in Practitioners' rooms**	• GP Network - subject to the Hospitalisation Limit. • Non-GP Network - subject to the Day-to-Day Limit. • Test & Procedures not specified - No Benefit. • ***Refer to Addendum C*** for a list of services.
• **Routine Diagnostic Endoscopic Procedures in Practitioners' rooms**	• Subject to the Hospitalisation Limit if procedure is done in the practitioners' rooms, and specifically authorised. • According to the MediPhila Procedure List. • The use of MediPhila GP Network applies. • ***Refer to Addendum B*** for the list of services.
MENTAL HEALTH Includes Consultations and Visits, Procedures, Assessments, Therapy, Treatment and/or Counselling.	• PMB only.
MENTAL HEALTH MEDICINE Medicine Management of a specific non-CDL condition, in conjunction with Psychotherapy sessions. Subject to the relevant Managed Healthcare Programme. The Medicine Exclusion List and the Pharmacy Products Management Document are applicable. Levies and co-payments to apply where relevant.	• **R5 600** per beneficiary. • Subject to the medicine formulary and Chronic DSP from Rand one.
INTRAUTERINE DEVICES AND ALTERNATIVES ***Refer to Addendum B*** for a list of services. Procedure to be performed in Practitioners' rooms. Includes consultation, pelvic ultrasound, sterile tray, device and insertion thereof. The use of the Medshield Specialist Network applies. Only applicable if no contraceptive medication is used. On application only and pre-authorisation applies. *Clinical Protocols apply.*	• **1 per female** beneficiary. • Includes all IUD brands up to and including the price of the Mirena device. • **Mirena/Kyleena device: 1 per female** beneficiary every 5 years. • **Implanon: 1 per female** beneficiary every 3 years. • **Nova T/Copper device: 1 per female** beneficiary every 2 years.

Wellness Benefits

Wellness Benefits are subject to the use of the relevant Pharmacy Network. Unless otherwise specified, benefits are subject to the Overall Annual Limit, thereafter subject to the Day-to-Day Limit:

BENEFIT CATEGORY	BENEFIT LIMITS AND COMMENTS
ADULT VACCINATION	• No Benefit.
COVID-19 VACCINATION Limited to Scheme Vaccination Formulary. Excludes consultation costs.	• Subject to the Overall Annual Limit. • Protocols apply.
BIRTH CONTROL (Contraceptive Medication) Only applicable if no intrauterine devices and alternatives are used.	• Restricted to **1 month's** supply to a maximum of **13 prescriptions per annum** per female beneficiary between the ages of 14 - 55 years. • **R150** per script.
FLU VACCINATION	• **1 per beneficiary** 18+ years old.
HEALTH RISK ASSESSMENT Pharmacy or General Practitioner. Includes the following tests: Cholesterol, Blood Glucose, Blood Pressure, Body Mass Index (BMI).	• **1 per beneficiary** 18+ years old per annum.
MAMMOGRAM (Breast Screening)	• **1 per female beneficiary** 40+ years old every 2 years.

Wellness Benefits

BENEFIT CATEGORY	BENEFIT LIMITS AND COMMENTS
HPV VACCINATION (Human Papillomavirus)	• **1 course of 2 injections** per female beneficiary 9+ years old.
NATIONAL HIV COUNSELLING TESTING (HCT)	• PMB and PMB level of care.
PAP SMEAR (excludes cost of the consultation)	• **1 per female** beneficiary, per annum.
PSA SCREENING (Prostate specific antigen)	• 1 **test** per male beneficiary between the ages of 50 - 59 years old.
TB TEST	• **1 test** per beneficiary, per annum.
CHILDHOOD VACCINATIONS Vaccination programme as per the Department of Health protocol and specific age groups.	• Included in the Overall Annual Limit.
At Birth: BCG -Bacillus Calmette Guerin Vaccine; OPV (0) - Oral Polio Vaccine; HBV (0) - Hepatitis B vaccine (specific neonates)*	
At 6 Weeks: OPV (1) - Oral Polio Vaccine; RV (1) - Rotavirus Vaccine*; DTaP-IPV-Hib_HBV (1) - Diphtheria, Tetanus, Acellular Pertussis, Inactivated Polio, Haemaphilus Influenzae type b and Hepatitis B Conjugate (Combined Vaccine); PCV (1) - Pneumococcal Conjugate Vaccine.	
At 10 Weeks: DTaP-IPV-Hib_HBV (2) - Diphtheria, Tetanus, Acellular Pertussis, Inactivated Polio, Haemaphilus Influenzae type b and Hepatitis B Conjugate (Combined Vaccine).	
At 14 Weeks: RV (2) - Rotavirus Vaccine*; DTaP-IPV-Hib_HBV (3) - Diphtheria, Tetanus, Acellular Pertussis, Inactivated Polio, Haemaphilus Influenzae type b and Hepatitis B Conjugate (Combined Vaccine); PCV (2) - Pneumococcal Conjugate Vaccine.	
At 6 Months: MR (1) - Measles and Rubella (Combined Vaccine)*	
At 9 Months: PCV (3) - Pneumococcal Conjugate Vaccine.	
At 12 Months: MR (2) - Measles and Rubella (Combined Vaccine)*	
At 15 Months: Chickenpox.	
At 18 Months: DTaP-IPV-Hib_HBV (4) - Diphtheria, Tetanus, Acellular Pertussis, Inactivated Polio, Haemaphilus Influenzae type b and Hepatitis B Conjugate (Combined Vaccine).	
At 6 Years: Tdap (1) - Tetanus, reduced strength of Diphtheria and Acellular Pertussis Vaccine; Chickenpox.	
At 9 Years+ (Girls only): Human Papilloma Virus (HPV).	
At 10-12 Years: Tdap (campaign) - Tetanus, reduced strength of Diphtheria and Acellular Pertussis Vaccine.	
At 12 Years: Tdap (2), Tetanus, reduced strength of Diphtheria and Acellular Pertussis Vaccine.	

***NOTES:**

- Hepatitis B (0) Vaccine (birth dose) - Given ONLY to infants whose mothers tested POSITIVE for HBsAg during pregnancy.
- Rotavirus Vaccine - DO NOT administer after 24 weeks.
- Measles and Rubella Vaccine at 6 months to LESS than 9 months. DO NOT administer with any other vaccine.
- Measles and Rubella Vaccine at 9 months and above. Can be administered with any other vaccine.
- Human Papilloma Virus Vaccine. All eligible girls in all settings.

Ambulance Services: 24 Hour Hotline: 086 100 6337

BENEFIT CATEGORY	BENEFIT LIMITS AND COMMENTS
EMERGENCY MEDICAL SERVICES Pre-authorisation from the Emergency Services Provider is required. **Including the following:** • 24 Hours access to Emergency Operation Centre. • Transfer from scene to the most appropriate facility for stabilisation and definitive care. • Medically justified transfers to special care centre or inter-facility transfers. • Telephone Medical Advice. *Clinical Protocols apply.*	• **Unlimited**. • Scheme approval required for Air Evacuation.

How to Access Hospital and Network Providers for my benefit option

Medshield's Healthcare Provider Networks are easily accessible on the Medshield website and the Mobile app.

Medshield website (www.medshield.co.za):

1. **OPEN** the Medshield website home page.
2. Click the '**MENU**' dropdown and select '**MEDSHIELD NETWORKS**' on the Member tab.
3. Navigate to and **CLICK** on your Benefit Option e.g. MediValue.
4. You will **FIND A LIST** of Provider Networks and Designated Service Providers (DSPs) for your plan. Simply **CHOOSE** the relevant plan and the Networks will be listed. These networks include Specialist networks, GP networks, pharmacy networks, chronic medicine DSP networks, dental and optical networks, SmartCare pharmacy networks, and oncology networks specific to each plan.
5. Each plan's list of Networks and DSPs has a **SMART SEARCH GEO LOCATOR** designed and built-in to make life easy. The Smart Search Geolocator feature lets you quickly find what you're looking for by typing in relevant provider name or practice number, or you can search by province and city keywords such as location, provider name, or practice number. This feature saves you time and eliminates the need for long, tedious searches. **To access the search screen, click on your preferred network and the search options will appear.**
6. Using the search options provided, **GEO LOCATOR INSTANTLY DISPLAYS A MAP** with the location results of the Provider you searched for.
7. The GEO Locator displays a **COMPREHENSIVE LIST OF PROVIDERS** within the province and city you searched for.
8. This Smart Search GEO Locator feature also allows you to **EXPORT AND DOWNLOAD A COMPREHENSIVE MICROSOFT EXCEL LIST** of all the General Practitioners (GPs) on the Medshield Network under your specific plan. With this list at your disposal, you can confidently search for network providers even if technological failures prevent your access to the Medshield website. **SMART SEARCH CATERS TO EACH USER'S NEEDS**, providing quick and efficient access to crucial information, such as finding a network provider.

Medshield App

1. **OPEN** the Medshield App and click on the '**MEMBER TOOLS TAB'** at the bottom of the screen
2. Click on the '**LOCATE NETWORK PROVIDER**' button
3. You will be rerouted to the Medshield website (**FOLLOW THE STEPS FROM 4 ABOVE**)

Ensure that your healthcare provider is part of your Benefit Option/Plan's relevant Network to minimise out-of-pocket expenses or co-payments.

How to Obtain a Hospital Pre-authorisation

Hospital pre-authorisation is an essential process that ensures cover for your hospital stay, treatment, or surgery. Getting approval in advance prevents unexpected out-of-pocket expenses and ensures your hospital admission is smooth and hassle-free.

Here is an easy guide to help you obtain hospital pre-authorisation with Medshield.

1.

Confirm the Hospital is in the Medshield Network

Before starting the pre-authorisation process, **check if the hospital you plan to use** is part of the Medshield Hospital Network for your benefit option or plan. You can easily verify this by visiting the Medshield website (**https://medshield.co.za/medshield-networks-2-0/**).

2.

Gather the Necessary Information

To obtain pre-authorisation, **make sure you have the following details** on hand:

- Membership number
- Patient's name and date of birth
- Contact details
- Reason for admission - ICD-10 and tariff codes (ask your doctor for these)
- Date and time of the procedure
- Name and contact information of the admitting doctor
- Name and contact information of the hospital
- Estimated length of stay

3.

Contact Medshield Hospital Benefit Management

Once you have all the necessary information, **you can request pre-authorisation** by:

- Calling Medshield Hospital Benefit Management at **086 000 2121** or **+27 11 671 2011**, *OR*
- Sending an email to **preauth@medshield.co.za** with the required information.

4.

Understand the Terms and Conditions

Upon receiving pre-authorisation, **ensure you understand the terms**, including which services and procedures are covered. In cases where your hospital stay is extended or additional services (e.g. physiotherapy/dietician) and procedures (e.g. prosthetics or MRI/CT scans) are required, these may require separate pre-authorisation. Failure to do so may result in out-of-pocket expenses.

5.

Pre-authorising Emergency Admissions

In case of an emergency, **you can get retrospective pre-authorisation within 48 hours** of hospital admission. If you do not follow this process, you may not be covered for the claims related to the emergency admission. A request for late hospital authorisation may be submitted however it will attract co-payments payable by you to the hospital.

6.

Follow Up and Adjust if needed

If your hospital admission is postponed or you are readmitted for the same condition, you must contact Medshield to **update the authorisation**. If the admission or procedure is cancelled, notify Medshield to cancel the pre-authorisation.

Following these steps ensure that your hospital admission goes smoothly and that the approved expenses are covered.

How to Apply for your Chronic Medicine and register on the Chronic Medicine Programme (CDL List)

If you have been diagnosed with a chronic condition you will require long-term medication. It is important to register your chronic medication so the payment of your medicine can be covered from your Chronic Medicine benefit and not your Day-to-Day benefits or Savings allocation.

FOLLOW THESE EASY STEPS:

1.

CALL OR EMAIL

Your doctor or Pharmacist can call Mediscor on **086 000 2120** (Choose the relevant option) or email **medshieldauths@mediscor.co.za**.

You will need the following information:

- Membership details: Benefit Option name and your membership number
- Patient details: Name, Dependant code (on the back of your membership card) and date of birth
- Your Doctor's details: Initials, surname and practice number
- Diagnosis details: What chronic condition has been diagnosed and the ICD-10 code
- Prescribed medicine: Medicine name, strength and dosing frequency

If additional information or a motivation is required, we will contact you and/or your treating doctor.

2.

REGISTRATION

Your registration will be evaluated in line with the Scheme Rules and Protocols by in-house qualified and registered pharmacists and pharmacy assistants. Your application will be processed according to the formularies appropriate for the condition and Benefit Option. Different types of formularies apply to the conditions covered under the various Benefit Options.

You can check online if your medication is on the formulary for your Benefit Option by visiting www.mediscor.co.za/search-client-medicine-Formulary/. If your medicine is not on the formulary for your Benefit Option you can ask your doctor if there is an alternative available that is on the formulary otherwise you will be liable for an upfront co-payment.

3.

AUTHORISATION

You will receive a standard medicine authorisation and treatment letter once your application for chronic medication has been processed.

If your registration requires additional test results or a motivation, you should follow up with your treating Doctor to provide this information.

4.

CHRONIC MEDICINE

Take your script to the Chronic Medicine Designated Service Provider (DSP) network pharmacy for your benefit option/plan and collect your medicine, or have it delivered.

Chronic Medicine Authorisation Contact Centre hours: Mondays to Fridays: 07:30 to 17:00

How to Register the DTP PMB Chronic Care Programme

Accessing chronic treatment through the DTP PMB (Designated Treatment Pair Prescribed Minimum Benefits) programme requires collaboration between members and healthcare providers. Below is a simple step-by-step process to guide you through the registration.

1.

Consult with Your Doctor

Schedule a consultation with your doctor or General Practitioner (GP) to confirm your diagnosis.

2.

Complete the Application Form

Once the diagnosis is confirmed, your doctor must complete the DTP PMB application form available on the Medshield website at **https://medshield.co.za/members/scheme-forms-for-members/**.

3.

Submit the Form

Your doctor must submit the completed form to Mediscor at **medshieldapmb@mediscor.co.za**.

4.

Review and Feedback

Mediscor will review the application and provide initial feedback to you, your provider, or your broker.

5.

Check for Validity and Classification

Mediscor will verify the application to determine whether your request qualifies for DTP PMB or CDL chronic treatment. If it's for chronic treatment, instructions will be provided to send the form to **medshieldauths@mediscor.co.za**.

6.

Processing the Request

If the application is classified as a DTP PMB request, **Mediscor will use clinical guidelines to review and finalise the request**.

7.

Outcome Notification

You and your doctor will receive the outcome of your request. Mediscor will issue a confirmation PMB letter and a treatment care plan if approved. If denied, detailed feedback explaining the decision will be provided.

8.

Annual Renewal

Ensure your DTP PMB treatment care plan is registered annually to continue receiving the necessary treatments.

By following these steps, you will receive the appropriate chronic care under the DTP PMB benefit.

How to Apply to Register on the Oncology Programme

The Medshield Oncology Disease Management Programme was created to ensure that cancer patients can access high-quality treatment and support through a network of designated oncology specialists. The Independent Clinical Oncology Network (ICON) is the Designated Service Provider (DSP) to deliver comprehensive cancer care.

Below is a step-by-step guide on applying and registering for Oncology benefits to receive the necessary care and treatment.

1.

Contact the Medshield Oncology Disease Management Team

When you receive a cancer diagnosis and are prepared to start treatment, contact **Medshield's Oncology Disease Management** team at **086 000 2121**. They will provide a list of ICON Oncology Group practices in your area. Once you have identified the most convenient practice, ask your doctor to refer you to an ICON Oncologist for treatment.

2.

Initial Consultation with an ICON Oncologist

Once referred, **schedule an appointment with your selected ICON Oncologist.** During the consultation, the Oncologist will discuss your treatment plan and submit it to Medshield for authorisation on your behalf.

3.

Treatment Plan Authorisation

The Medshield Oncology Disease Management team will collaborate with your ICON Oncologist to review and approve the treatment plan. **Once approved, an authorisation letter will be sent to you and your Oncologist**, detailing the treatment, quantities, and authorisation duration.

4.

Renewal of Treatment Plan

If your Oncologist is not part of the ICON DSP network, you must consult with an ICON Oncologist when renewing your treatment plan. To check if your Oncologist is part of the network, contact Medshield or visit https://medshield.co.za/medshield-networks-2-0/.

5.

Co-payments for Non-ICON Oncologists

If you continue treatment with a non-ICON Oncologist after renewing your plan, a co-payment will be applied, meaning Medshield will only cover a certain percentage of your claim. You will be responsible for the remaining balance.

6.

Follow Scheme Protocols

Oncology treatment is covered according to Medshield and ICON protocols, regardless of your Oncologist's network status. Ensure your Oncologist adheres to these protocols to avoid complications with claim payments.

These steps will ensure you receive comprehensive Oncology care through Medshield's ICON Network while maximising your benefits and minimising potential out-of-pocket costs.

How to Check and Submit Your Optical Claims

Get the most out of your optical benefits with our easy 3-step process for checking your availabe benefits and submitting claims.

FOLLOW THESE EASY STEPS:

1.

Confirm Your Optical Benefits

Before visiting your heathcare provider, confirm the availability of your optical benefit or remaining funds by contacting IsoLeso:

- Call: **011 340 9200**
- Email: **medshield@isoleso.co.za**

2.

Details that should be visable on a claim

Ensure the following is displayed on your healthcare provider account before submitting your claim:

- Service provider (Optometrist) practice number
- Optical codes for frames and lenses
- ICD-10 Code/s
- Date of treatment

3.

Submit your claim

Once you've gathered all required information, submit your claim via email:

- Email: **medshieldclaims@isoleso.co.za**

For assistance or further inquiries, please contact the Medshield Contact Centre on **086 000 2120**.

How to Obtain Pre-authorisation for Dental Services

To ensure smooth access to your dental services, follow these simple steps to obtain pre-authorisation. Remember, confirming your benefits and providing accurate information is vital to receiving the necessary authorisation for your treatment.

FOLLOW THESE EASY STEPS:

1.

Confirm availability of benefits/funds

Before proceeding, ensure that your benefits/funds or savings for basic and/or specialised dentistry or maxillo-facial surgery are available. You can confirm this by contacting **086 000 2120**.

2.

Gather all required information

Make sure you have the following details ready when requesting pre-authorisation:

- Service provider (Dentist/ Orthodontist/Maxillo-facial) practice number
- Procedure/Dental codes
- Tooth number/s
- ICD-10 Code/s
- Treatment date
- X-ray results
- Letter of motivation for Orthodontic treatment or crowns/bridges and implants

3.

Send an email for authorisation

Once you have the necessary details, send your authorisation request to the appropriate email address based on the type of dental service you require:

- For periodontic treatment: perio@denis.co.za
- For in-Hospital authorisation: hospitalenq@denis.co.za
- For specialised dentistry: customercare@denis.co.za
- For orthodontic treatment: ortho@denis.co.za

Important Reminder: Cover for treatment under your option when the claim is processed, is subject to the Medshield's Scheme Rules, managed care protocols, exclusions, co-payments, financial limits, and/or available savings. All claims will be processed at the scheme tariff, provided your membership is in good standing with contributions paid up to date.

How to Access MedshieldMOM Additional Services

Motherhood is a journey filled with love, care, and responsibility, even before your child's birth. Medshield understands this special bond and is committed to walking alongside mothers through each pregnancy, childbirth, and post-partum phase. The MedshieldMOM website offers extensive resources and services to support mothers during this journey.

STEPS TO ACCESS MEDSHIELD MOM SERVICES:

1.

Visit the Medshield MOM Website

Start by visiting the Medshield MOM website at **www.medshieldmom.co.za**. This user-friendly platform is a hub of essential health, nutrition, fitness, and motherhood content, covering both pre- and post-partum stages.

2.

Register Your Pregnancy Journey

Once on the website, you can register your pregnancy journey by entering the specific week of your pregnancy. This registration allows you to receive tailored content based on the stage of your pregnancy, including professional advice, regular updates on your baby's development, and important reminders for doctor appointments and hospital pre-authorisation.

3.

Book Your Medshield MOM Bag

During your **third trimester**, you can request the exclusive MedshieldMOM bag packed with Bennetts products for your baby. To book your bag, email **medshieldmom@medshield.co.za** with your membership number, contact details, and delivery address.

4.

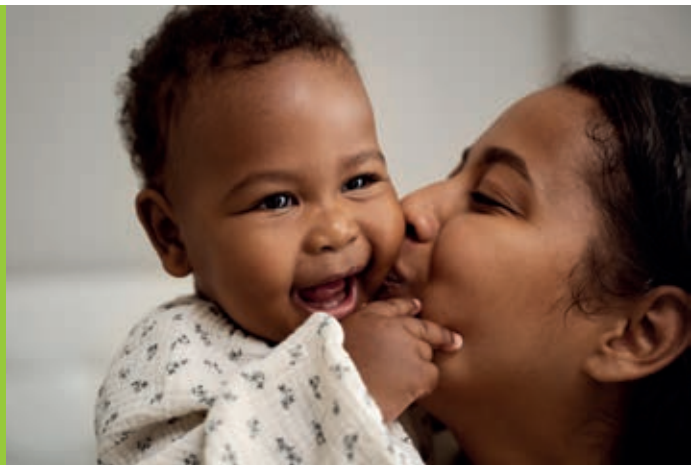
Pre-Authorise for Hospital Admission

Before the birth of your baby, ensure that you obtain hospital pre-authorisation. Contact **Medshield's Managed Healthcare Programme** at **086 000 2121** or email **preauth@medshield.co.za** with the timeline from your doctor to complete the pre-authorisation process.

5.

Register Your Baby as a Dependant

After your baby is born, register them as a newborn beneficiary within 60 days to ensure they are covered under your Medshield membership. If there are any delays in receiving the birth certificate, contact **Medshield's Contact Centre** at **086 000 2120** for assistance.



MedshieldMOM is here to support mothers at every stage, providing convenient access to vital services and benefits. These simple steps can ensure a smoother, less stressful journey through pregnancy and beyond while enjoying the many benefits of being a Medshield member.

How to Access SmartCare Nurse and Nurse-led GP Virtual Consultations

SmartCare offers Medshield members convenient access to healthcare through registered nurse consultations and nurse-led virtual General Practitioner (GP) consultations with specified healthcare practitioners. This evolving healthcare benefit is designed to provide both acute and chronic consultations for various medical conditions.

Here's a simple step-by-step guide on how to access your SmartCare Benefits:

1. **VISIT A SMARTCARE-SUPPORTED PHARMACY**
Locate and visit a pharmacy that supports SmartCare services. Your SmartCare Provider Network is on the Medshield Website, **www.medshield.co.za**, under **Menu** > **Member** > **Medshield Networks**. **SELECT YOUR PLAN** and then choose SmartCare Pharmacy Network.
Upon arrival, inform the staff that you would like to use the SmartCare service for a virtual consultation.

2. **NURSE CONFIRMS MEDSHIELD BENEFITS**
A **registered nurse will confirm your Medshield membership** and check your benefits to ensure eligibility for the consultation.

3. **MEDICAL HISTORY REVIEW AND EXAMINATION**
The nurse will review your medical history and perform a clinical examination.
Based on the results, the nurse will either recommend Over-the-Counter (OTC) medication or advise that a doctor consultation is necessary.

4. **VIRTUAL DOCTOR CONSULTATION** (if needed)
If a doctor's consultation is required, the nurse will initiate a video call with the doctor. The nurse assists by sharing your medical history and results with the doctor, who will conduct the consultation remotely. **The doctor will generate a prescription and send it directly to the pharmacy**.

5. **COLLECT MEDICATION**
After the consultation, you can collect any prescribed or recommended medication from the pharmacy, whether Over-the-Counter or prescription medicine.

SmartCare offers a seamless process for accessing healthcare without needing to visit a doctor's office. Using virtual consultations and with the support of trained nurses, Medshield members can receive timely medical advice, prescriptions, and treatments for both acute and chronic conditions.

Terms & Conditions: No children under the age of 2 may be seen for anything other than a prescription for a routine immunisation. No consultations related to mental health. No treatment of emergency conditions involving heavy bleeding and/or trauma. No treatment of conditions involving sexual assault. SmartCare services cannot provide Schedule 5 and up medication. Over-the-Counter (OTC) and prescription medication is subject to the Pharmacy Advised Therapy Script Limit as per the Scheme Rules and chosen benefit option. Clinics trading hours differs and are subject to store trading hours.

How to Register on the Medshield Website and Mobile App Member Login Zones

The member login portal on both the Medshield website and mobile App is designed to provide you with seamless access to your healthcare information. Whether using the website or App, registration is simple and essential for managing your health benefits.

Website Registration Process:

If you've already registered on the App, the same credentials can be used on both, making your healthcare journey even more convenient.

1. **Navigate to the Member Login Page**
   Visit the Medshield website (**www.medshield.co.za**) and click on the "**MEMBER LOGIN**" button at the top-right of the homepage.

2. **Initiate Registration**
   Click on the "**CREATE ACCOUNT**" option. ***Enter your membership number*** in the designated field and click "**VALIDATE**."

3. **Enter Personal Details**
   After validation, fill in your ID number, email address, preferred username, and password. The password must be at least eight characters long, case-sensitive, and must not contain ampersands (&) or spaces.

4. **Agree to Terms and Conditions**
   Review the Medshield website's terms and conditions, then click "**AGREE**" to proceed.

5. **Complete Registration:**
   Once all details are submitted, click "**REGISTER**." You can ***now access the member login zone*** using your newly created credentials.

Website Registration Process:

If you've already registered on the website, the same credentials can be used on both, making your healthcare journey even more convenient.

1. **Open the Medshield App**
   Download and launch the Medshield App from any PlayStore or IOS App Store on your mobile device. On the login screen, tap on "**CREATE ACCOUNT**."

2. **Validate Membership Number**
   Enter your membership number and select whether you are registering as a principal member or a beneficiary. Click "**VALIDATE**" to proceed.

3. **Complete Personal Details**
   After validation, fill in your ID number, email address, preferred username, and password. The password must be at least eight characters long, case-sensitive, and must not contain ampersands (&) or spaces.

4. **Agree to Terms and Conditions**
   Review and accept the App's terms and conditions, then click "**REGISTER**."

5. **Log In to Your Account:**
   Once registration is successful, ***return to the login screen*** and use your new credentials to access the App.

Registering on the website and mobile app member login zones gives you full access to easily manage your health benefits.

How to Blow the Whistle on Fraud, Waste and Abuse

Did you know that healthcare fraud can contribute directly and indirectly to the rise of medical costs, including your membership contribution? You have the power to help us prevent fraud for the greater good of all our members. You are encouraged to use any of the dedicated Whistle Blowers hotline reporting channels to report any suspected medical aid fraud.

HOW CAN YOU HELP?

- Check your claim statements carefully and ensure you received the services your service provider is claiming.
- Make sure your membership card and number are protected.
- Don't accept cash from a service provider in exchange for a medical aid claim.
- Report suspicious behaviour.

Eight Ways to Submit a Report to the Whistle Blowers Ethics Hotline

Call directly on the toll-free number 0800 112 811
Use the dedicated Whistle Blowers hotline number to make a report via the live answering service.

SMS to 33490
Send your report via the SMS line from anywhere in South Africa at a cost of R1.50.

Report online at www.whistleblowing.co.za
Visit the Whistle Blowers website to report and make your submission via the online reporting platform.

Email to information@whistleblowing.co.za
Send an email of your report privately to Whistle Blowers.

Download and use the Whistle Blowers app
Download the secure Whistle Blowers app from Google Play or the Apple App Store. The app guides you through the reporting process.

Post a letter of your report
Send a letter of your report to Whistle Blowers via post using the below details:
Freepost KZN665, Musgrave, South Africa, 4062

Fax your report
Send your report to Whistle Blowers via a fax line: **Toll-free on 0800 212 689**

WhatsApp
Send your report to Whistle Blowers via WhatsApp on: **031 308 4446**

REMEMBER, reports can be submitted **ANONYMOUSLY** or in **CONFIDENCE**.

Medshield Partners' Contact Details

SERVICE	PARTNER	CONTACT DETAILS
Ambulance and Emergency Services	Netcare 911	**Contact number:** 086 100 6337 (+27 10 209 8011) for members outside of the borders of South Africa
Chronic Medicine Authorisations and Medicine Management	Mediscor	**Contact number:** 086 000 2120 (Choose relevant option) or contact +27 10 597 4701 for members outside the borders of South Africa **Facsimile:** 0866 151 509 **Authorisations:** medshieldauths@mediscor.co.za
Dental Authorisations	Denis	**Contact number:** 086 000 2121 (+27 11 671 2011) for members outside of the borders of South Africa - Crowns/Bridges and Dental Implant Authorisations **email:** crowns@denis.co.za - Periodontic Applications **email:** perio@denis.co.za - Orthodontic Applications **email:** ortho@denis.co.za - Plastic Dentures **email:** customercare@denis.co.za In-Hospital Dental Authorisations **email:** hospitalenq@denis.co.za
Diabetes Care Programme	Medshield	**Contact number:** 086 000 2120 (+27 10 597 4701) for members outside the borders of South Africa **Facsimile:** +27 10 597 4706 **email:** Diabetesdiseasemanagement@medshield.co.za
Disease Management Care Plans	Mediscor	**Contact number:** 086 000 2120 (+27 10 597 4701) for members outside of the borders of South Africa **Facsimile:** +27 10 597 4706 **email:** pmbapplications@medshield.co.za
HIV and AIDS Management	HaloCare	**Contact number:** 086 014 3258 (Mon - Fri: 07h30 to 16h00) **Facsimile:** 086 570 2523 **email:** medshield@halocare.co.za
HIV Medication Designated Service Provider (DSP)	Pharmacy Direct	**Contact number:** 086 002 7800 (Mon to Fri: 07h30 to 17h00) **Facsimile:** 086 611 4000/1/2/3 **email:** care@pharmacydirect.co.za
Hospital Authorisations	Medscheme	**Contact number:** 086 000 2121 (+27 11 671 2011) for members outside of the borders of South Africa **email:** preauth@medshield.co.za
Hospital Claims	Medscheme	**Contact number:** 086 000 2121 (+27 11 671 2011) for members outside of the borders of South Africa Working Hours: Mon - Fri: 08h00 - 17h00 **email:** hospitalclaims@medshield.co.za
Oncology Disease Management Programme (for Cancer treatment)	ICON and Medscheme	**Contact number:** 086 000 2121 (+27 11 671 2011) for members outside of the borders of South Africa **email:** oncology@medshield.co.za Medshield has partnered with the Independent Clinical Oncology Network (ICON) for the delivery of Oncology services. Go to the ICON website: www.cancernet.co.za for a list of ICON oncologists
Optical Services	Iso Leso Optics	**Contact number:** 086 000 2120 (+27 10 597 4701) for members outside of the borders of South Africa **Facsimile:** +27 11 782 5601 **email:** member@isoleso.co.za

DSP and Managed Care Partners' Contact Details

SERVICE	PARTNER	CONTACT DETAILS
DISEASE MANAGEMENT		
Mental Health	Mediscor	**Email:** medshieldapmb@mediscor.co.za
HIV	Mediscor	**Contact number:** 086 014 3258 (Mon to Fri: 07h30 to 17h00) **Email:** medshield@halocare.co.za
Chronic Medicine Authorisations and Medicine Management	Mediscor	**Contact number:** 086 000 2120 (Choose relevant option) or contact +27 10 597 4701 for members outside the borders of South Africa **Authorisations:** medshieldauths@mediscor.co.za
Diabetes	Medshield	**Contact number:** 086 000 2120 (+27 10 597 4701) for members outside the borders of South Africa **Email:** diabetesdiseasemanagement@medshield.co.za
Hypertension	Medshield	**Contact number:** 086 000 2120 (+27 10 597 4701) for members outside the borders of South Africa **Email:** diabetesdiseasemanagement@medshield.co.za
Hyperlipideamia	Medshield	**Contact number:** 086 000 2120 (+27 10 597 4701) for members outside the borders of South Africa **Email:** diabetesdiseasemanagement@medshield.co.za
Renal	Medshield	**Contact number:** 086 000 2121 (+27 11 671 2011) for members outside the borders of South Africa **Email:** preauth@medshield.co.za
Prosthesis and Devices: Internal	Major Joints for Life (MJ4L)	**Contact number:** +27 11 219 9111 **Email:** majorjointsforlife@lifehealthcare.co..za
Prosthesis and Devices: Internal	Improved Clinical Pathway Services (ICPS)	**Contact number:** +27 11 327 2599 **Email:** admin@icpservices.co.za
HAH (Hospital at Home)	Medscheme	**Contact number:** 086 000 2121 (+27 11 671 2011) for members outside the borders of South Africa **Email:** preauth@medshield.co.za
Wound Care	Medshield	**Contact number:** 086 000 2121 (+27 11 671 2011) for members outside the borders of South Africa **Email:** preauth@medshield.co.za
Private Nursing	Medshield	**Contact number:** 086 000 2121 (+27 11 671 2011) for members outside the borders of South Africa **Email:** preauth@medshield.co.za
Renal	NRC Patel and Partners	NRC: **Contact number:** +27 11 726 5206 Patel and Partners: **Contact number:** +27 11 219 9720
	Patel and Partners (East Rand Dialysis Inc)	**Contact number:** +27 11 677 8704

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 (CO-PAYMENTS WILL APPLY IN-HOSPITAL*)

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

Note: **No co-payment applicable In-Hospital for children 8 years and younger. The above is not an exhaustive list.*

Addendum C

TARIFF CODE	DESCRIPTION
0190 -0192	FP Consultations

Tariffs that can be charged in addition to a consultation (cost of material included):

TARIFF CODE	DESCRIPTION
202	Setting of sterile tray
206	Intravenous treatment (all ages)
241	Cauterization of warts/chemocryotherapy of lesions
242	Cauterization of warts/chemocryotherapy of lesions - Additional
255	Drainage of abscess and avulsion of nail
259	Removal of foreign body
300	Stitching of wound (additional code for setting sterile tray)
301	Stitching of an additional wound
307	Excision and repair
310	Radical excision of nail bed in rooms
887	Limb cast
1232	Resting ECG (including electrodes)
1725	Drainage of external thrombosed pile
4614	HIV rapid test
	Health Risk Assement Test (HRAT): Cholesterol, Blood Glucose, Blood Pressure, Body Mass Index (BMI)

Addendum D - MediPhila Pathology Formulary

TARIFF CODE	DESCRIPTION	SUBJECT TO AUTHORISATION
A. CHEMISTRY		
CARDIAC / MUSCLE		
4152	CK-MB: Mass determination: Quantitative (Automated)	No
4161	Troponin isoforms: Each	No
DIABETES		
4057	Glucose: Quantitative	No
4064	HbA1C	No
INFLAMMATION / IMMUNE		
3947	C-reactive protein	No
LIPIDS		
4027	Cholesterol total	No
4026	LDL cholesterol	No
4028	HDL cholesterol	No
4147	Triglyceride	No
LIVER / PANCREAS		
3999	Albumin	No
4001	Alkaline phosphatase	No
4006	Amylase	No

TARIFF CODE	DESCRIPTION	SUBJECT TO AUTHORISATION
4009	Bilirubin: Total	No
4010	Bilirubin: Conjugated	No
4117	Protein: Total	No
4130	Aspartate aminotransferase (AST)	No
4131	Alanine aminotransferase (ALT)	No
4133	Lactate dehidrogenase (LD)	No
4134	Gamma glutamyl transferase (GGT)	No
RENAL / ELECTROLYTES / BONE		
4017	Calcium: Spectrophotometric	No
4032	Creatinine	No
4086	Lactate	No
4094	Magnesium: Spectrophotometric	No
4109	Phosphate	No
4113	Potassium	No
4114	Sodium	No
4155	Uric acid	No
4151	Urea	No
B. HAEMATOLOGY		
CEREBROSPINAL FLUID		
3709	Antiglobulin test (Coombs' or trypsinzied red cells)	No
3716	Mean cell volume	No
3743	Erythrocyte sedimentation rate	No
3755	Full blood count (including items 3739, 3762, 3783, 3785, 3791)	No
3762	Haemoglobin estimation	No
3764	Grouping: A B and O antigens	No
3765	Grouping: Rh antigen	No
3797	Platelet count	No
3805	Prothrombin index	No
3809	Reticulocyte count	No
3865	Parasites in blood smear	No
4071	Iron	No
4144	Transferrin	No
4491	Vitamin B12	No
4528	Ferritin	No
4533	Folic acid	No
C. ENDOCRINE - REPRODUCTIVE		
4450	HCG: Monoclonal immunological: Qualitative	No
4537	Prolactin	No
ENDOCRINE - THYROID		
4482	Free thyroxine (FT4)	No
4507	Thyrotropin (TSH)	No
OTHER ENDOCRINE		
4519	Prostate specific antigen	No
D. SEROLOGY		
AUTO IMMUNE		
3934	Auto antibodies by labelled antibodies: FOR ANF ONLY	No
3939	Agglutination test per antigen	No
4155	Uric acid	No
4182	Quantitative protein estimation: Nephelometer or Turbidometeric method: FOR RHEUMATOID FACTOR ONLY	No
Hepatitis tests		
4531	Hepatitis: Per antigen or antibody	No
4531	Acute hepatitis A (IgM)	No
4531	Chronic Hepatitis A (IgG)	No

TARIFF CODE	DESCRIPTION	SUBJECT TO AUTHORISATION
4531	Acute Hepatitis B (BsAG)	No
4531	Hepatitis B: carrier/ immunity (BsAB)	No
HIV tests		
3816	T and B-cells EAC markers (limited to ONE marker only for CD4/8 counts)	No
3932	Antibodies to human immunodeficiency virus (HIV): ELISA	No
3974	Qualitative PCR (only for children < age 6 months)	Yes
4429	Quantitative PCR (DNA/RNA)	Yes
INFECTIOUS DISEASES AND OTHERS		
3946	IgM: Specific antibody titer: ELISA/EMIT: RUBELLA	No
3948	IgG: Specific antibody titer: ELISA/EMIT: RUBELLA	No
3951	Quantatative Kahn, VDRL or other flocculation	No
E. CYTOLOGY		
4566	Vaginal or cervical smears, each	No
F. HISTOLOGY		
4567	Histology per sample	No
G. MISCELLANEOUS		
4352	Faecal occult blood test (FOB)	No
H. MICROBIOLOGY		
MCS		
3909	Anaerobe culture: Limited procedure	No
3901	Fungal culture	No
3918	Mycoplasma culture: Comprehensive	No
4401	Cell count	No
4188	Urine dipstick, per stick (irrespective of the number of tests on stick)	No
3928	Antimicrobic substances	No
3893	Bacteriological culture: Miscellaneous	No
3867	Miscellaneous (body fluids, urine, exudate, fungi, pus, scrapings, etc.)	No
3922	Viable cell count	No
3879	Campylobacter in stool: Fastidious culture	No
3895	Bacteriological culture: Fastidious organisms	No
3928	Antimicrobic substances	No
3887	Antibiotic susceptibility test: Per organism	No
3924	Biochemical identification of bacterium: Extended	No
3869	Faeces (including parasites)	No
3868	Fungus identification	No
3881	Mycobacteria	No
3901	Fungal culture	No
3868	Fungus identification	No
AFB FLUOROCHROME AURAMINE (ZN) ONLY		
3885	Cytochemical stain	No
3881	Antigen detection with monoclonal antibodies	No
TB CULTURE		
3881	Antigen detection with monoclonal antibodies	No
4433	Bacteriological DNA identification (LCR)	No
3916	Radiometric tuberculosis culture	No
3867	Miscellaneous (body fluids, urine, exudate, fungi, pus, scrapings, etc.)	No
3895	Bacteriological culture: Fastidious organisms	No
TB SENSITIVITY		
3887	Antibiotic susceptibility test: Per organism	No
3974	Polymerase chain reaction	Yes
EXTRAPULMONARY TB		
4139	Adenosine deaminase (CSF, Peritoneal or Pleural)	No
PARASITES		
3869	Faeces (including parasites)	No

TARIFF CODE	DESCRIPTION	SUBJECT TO AUTHORISATION
3883	Concentration techniques for parasites	No
3865	Parasites in blood smear	No
BILHARZIA MICRO		
3980	Bilharzia Ag Serum/Urine	No
3867	Miscellaneous (body fluids, urine, exudate, fungi, pus, scrapings, etc.)	No
3946	IgM: Specific antibody titer:ELISA/EMIT: Per Ag	No
3883	Concentration techniques for parasites	No

Addendum E - MediPhila Radiology Formulary

MEDICAL PRACTITIONER	RADIOLOGIST	RADIOGRAPHY	CODE DESCRIPTION
GENERAL			
		39300	X-Ray films
SKULL AND BRAIN			
3349	10100	39039	X-ray of the skull
FACIAL BONES AND NASAL BONES			
3353	11100	39043	X-ray of the facial bones
3357	11120	39047	X-ray of the nasal bones
ORBITS AND PARANASAL SINUSES			
3353	12100	39043	X-ray orbits
3351	13100	39041	X-ray of the paranasal sinuses, single view
	13110		X-ray of the paranasal sinuses, two or more views
MANDIBLE, TEETH AND MAXILLA			
3355	14100	39045	X-ray of the mandible
3361	14130	39051	X-ray of the teeth single quadrant
3363	14140	39053	X-ray of the teeth more than one quadrant
3365	14150	39055	X-ray of the teeth full mouth
3361	15100	39059	X-ray tempero-mandibular joint, left
3361	15110	39059	X-ray tempero-mandibular joint, right
3359	16100	39049	X-ray of the mastoids, unilateral
3359	16110	39049	X-ray of the mastoids, bilateral
THORAX			
3445	30100	39107	X-ray of the chest, single view
	30110	39107	X-ray of the chest two views, PA and lateral
3449	30150	39107	X-ray of the ribs
ABDOMEN AND PELVIS			
3477	40100	39125	X-ray of the abdomen
	40105	39125	X-ray of the abdomen supine and erect, or decubitus
	40110		X-ray of the abdomen multiple views including chest
SPINE			
3321		39017	Skeleton: Spinal column - Per region, e.g. cervical, sacral, lumbar coccygeal, one region thoracic
	50100	39025	X-ray of the spine scoliosis view AP only
3321	51110	39017	X-ray of the cervical spine, one or two views
3321	52100	39017	X-ray of the thoracic spine, one or two views
3321	53110	39017	X-ray of the lumbar spine, one or two views
3321	54100	39017	X-ray of the sacrum and coccyx
	54110	39027	X-ray of the sacro-iliac joints
PELVIS AND HIPS			
3331	55100	39027	X-ray of the pelvis
6518	56100	39017	X-ray of the left hip

MEDICAL PRACTITIONER	RADIOLOGIST	RADIOGRAPHY	CODE DESCRIPTION
6518	56110	39017	X-ray of the right hip
	56120		X-ray pelvis and hips
UPPER LIMB			
6509	61100	39003	X-ray of the left clavicle
6509	61105	39003	X-ray of the right clavicle
6510	61110	39003	X-ray of the left scapula
6510	61115	39003	X-ray of the right scapula
6508	61120	39003	X-ray of the left acromio-clavicular joint
6508	61125	39003	X-ray of the right acromio-clavicular joint
6507	61130	39003	X-ray of the left shoulder
6507	61135	39003	X-ray of the right shoulder
6506	62100	39003	X-ray of the left humerus
6506	62105	39003	X-ray of the right humerus
6505	63100	39003	X-ray of the left elbow
6505	63105	39003	X-ray of the right elbow
6504	64100	39003	X-ray of the left forearm
6504	64105	39003	X-ray of the right forearm
6500	65100	39003	X-ray of the left hand
6500	65105	39003	X-ray of the right hand
3305	65120	39001	X-ray of a finger
6501	65130	39003	X-ray of the left wrist
6501	65135	39003	X-ray of the right wrist
6503	65140	39003	X-ray of the left scaphoid
6503	65145	39003	X-ray of the right scaphoid
LOWER LEG			
6514	73100	39003	X-ray of the left lower leg
6514	73105	39003	X-ray of the right lower leg
6512	74100	39003	X-ray of the left ankle
6512	74105	39003	X-ray of the right ankle
6511	74120	39003	X-ray of the left foot
6511	74125	39003	X-ray of the right foot
6513	74130	39003	X-ray of the left calcaneus
6513	74135	39003	X-ray of the right calcaneus
6511	74140	39003	X-ray of both feet – standing – single view
3305	74145	39001	X-ray of a toe
FEMUR			
6517	71100	39003	X-ray of the left femur
6517	71105	39003	X-ray of the right femur
6515	72100	39003	X-ray of the left knee one or two views
6515	72105	39003	X-ray of the right knee one or two views
	72120	39003	X-ray of the left knee including patella
	72125	39003	X-ray of the right knee including patella
6516	72140	39003	X-ray of left patella
6516	72145	39003	X-ray of right patella
	72150	39003	X-ray both knees standing – single view
6519	74150	39003	X-ray of the sesamoid bones one or both sides
CT SCANS			
6416	13300		CT of the paranasal sinuses single plane, limited study
6417	13300		CT of the paranasal sinuses single plane, limited study
ULTRASOUND ABDOMEN AND PELVIS			
5102	61200		Ultrasound of the left shoulder joint
5102	61210		Ultrasound of the right shoulder joint
	41200		Ultrasound study of the upper abdomen
3627	40210		Ultrasound study of the whole abdomen including the pelvis
3618	43200	39147	Ultrasound study of the pelvis transabdominal

MEDICAL PRACTITIONER	RADIOLOGIST	RADIOGRAPHY	CODE DESCRIPTION
3615	43250	39145	Ultrasound study of the pregnant uterus, first trimester
	43270	39145	Ultrasound study of the pregnant uterus, third trimester, first visit
	43273	39145	Ultrasound study of the pregnant uterus, third trimester, follow-up visit
3615	43277	39145	Ultrasound study of the pregnant uterus, multiple gestation, second or third trimester, first visit
3617	43260	39145	Routine obstetric ultrasound at 20 to 24 weeks to include detailed anatomical assessment

Exclusions

1. **BENEFITS EXCLUDED insofar as these are not prescribed under the Prescribed Minimum Benefits LEVEL OF CARE**

General Exclusions

Unless otherwise decided by the Scheme, with the express exception of medicines or treatment approved and authorised in terms of any relevant Managed Healthcare Programme, expenses incurred in connection with any of the following will not be paid by the Scheme:

- All costs that exceed the annual or biennial maximum allowed for the particular category as set out in Annexure B, for the benefits to which the member is entitled in terms of the rules;
- All costs for operations, medicines, treatments and procedures for cosmetic purposes or for personal reasons and not directly caused by or related to illness, accident or disease;
- All costs for healthcare services if, in the opinion* of the Medical or Dental Adviser, such healthcare services are not appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition at an affordable level of service and cost; (*opinion in this instance will be based on current practice, evidence-based medicine, cost effectiveness and affordability for the claim to be excluded);
- All costs for medicines for the treatment of chronic conditions not on the list of diseases covered, with the exception of medicines for the treatment of an excluded chronic condition which the Chronic Medicine Programme has specifically determined should be treated to achieve overall cost-effective treatment of the beneficiary;

Exclusions and Indemnity in Regard to Third Party Claims

- It is recorded that the relationship between the Scheme and its members shall at all times be deemed to be one of the utmost good faith.
  The member therefore acknowledges and agrees that, notwithstanding anything to the contrary, or not specifically set out in the rules or Annexures of the Scheme, the member is under a duty of care to disclose all and any information or matters to the Scheme, which may in any manner impact upon or affect a decision or discretion which vests in the Scheme, concerning such member, any of his dependants or a claim;
- The Scheme shall affect payment of any claims, for both Prescribed and non-Prescribed Minimum Benefit level of care, incurred by the member, arising from the actions or omissions of any other third party and for such claim.

Exclusions in Regard to Non-Registered Service Providers

The Scheme shall not pay the costs for services rendered by:

- Persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or
- Any institution, nursing home or similar institution, except a state or provincial hospital, not registered in terms of any law;
- Any person that does not have a practice code number, group practice number or an individual practice number issued by the registering authorities for providers, if applicable.

Items not mentioned in Annexure B

- Accommodation in spa's, health resorts and places of rest for recuperative purposes, even if prescribed by a treating provider;
- Appointments which a beneficiary fails to keep;
- Autopsies;
- Cryo-storage of foetal stemcells and sperm;
- Delivery charges or fees;
- Exams, reports or tests requested for insurance, employment, visas (Immigration or travel purposes), pilot and drivers' licences, and school readiness tests;
- Medicines prescribed by a person not legally entitled thereto;
- Nuclear or radio-active material or waste;
- Travelling expenses & accommodation (unless specifically authorised for an approved event);
- Veterinary products;

SmartCare Clinics - Private Nurse Practitioner has the following exclusions:

- No children under the age of 2 other than for a prescription for a routine immunisation;
- No consultations related to mental health;
- No treatment of emergency conditions involving heavy bleeding and/or trauma;
- No treatment of conditions involving sexual assault;
- SmartCare services cannot provide Schedule 5 and higher medication.

Pathology and Medical Technology

- Allergy and Vitamin D testing in hospital;
- Exclusions as per the Schemes Pathology Management Programme;
- Gene Sequencing.

Pharmaceutical Electronic Standards Authority

- Pharmacy Product Management Document listing the PESA Exclusions, can be found in Annexure C1.

Specific Exclusions

All costs for services rendered in respect of the following unless specifically authorised by the Scheme.

Alternative Healthcare Practitioners

All services not listed in paragraph D1 of Annexure B's:

- Aromatherapy;
- Art therapy;
- Ayurvedics;
- Herbalists;
- Iridology;
- Reflexology;
- Therapeutic Massage Therapy (Masseurs)

Ambulance Services

- Services, subject to Regulation 8(3), not stipulated or included in the Preferred Provider contract. Refer to paragraph D2 of Annexure B. (excludes retrospective authorisations)

Appliances, External Accessories and Orthotics

- Appliances, devices and procedures not scientifically proven or appropriate;
- Back rests and chair seats;
- Bandages and dressings (except medicated dressings and dressings used for a procedure or treatment);
- Beds, mattresses, linen savers, pillows and overlays;
- Cardiac assist devices – e.g. Berlin Heart (unless PMB level of care, DSP applies);
- CPAP machines, unless specifically authorised;
- Diagnostic kits, agents and appliances unless otherwise stated (except for diabetic accessories) (unless PMB level of care);
- Electric wheelchairs and scooters;
- Electric toothbrushes;
- Exercise machines;
- Humidifiers;
- Insulin pumps unless specifically authorised;
- Ionizers and air purifiers;

- Orthopaedic shoes, inserts/levellers and boots, unless specifically authorised and unless PMB level of care;
- Oxygen hire or purchase, unless authorised and unless PMB level of care;
- Pain relieving machines, e.g. TENS and APS;
- Stethoscopes;
- Wearable monitoring devices.

Blood, Blood Equivalents and Blood Products
- Hemopure (bovine blood), unless acute shortage of human blood and blood products for acutely anaemic patients;

Dentistry
Exclusions as determined by the Schemes Dental Management Programme:

Additional Scheme Exclusions
- Appointments not kept;
- Behaviour management;
- Caries susceptibility and microbiological tests;
- Cost of mineral trioxide;
- Dental testimony, including dentolegal fees;
- Electrognathographic recordings, pantographic recordings and other such electronic analyses;
- Enamel microabrasion.
- Intramuscular and subcutaneous injections;
- Procedures that are defined as unusual circumstances and procedures that are defined as unlisted procedures;
- Pulp tests;
- Special reports;
- Treatment plan completed (code 8120);

Crown and Bridge
- Emergency crowns that are not placed for immediate protection in tooth injury, and the associated laboratory costs;
- Crown on 3rd molars;
- Crown and bridge procedures for cosmetic reasons and the associated laboratory costs;
- Crown and bridge procedures where there is no extensive tooth structure loss and associated laboratory costs;
- Cost of gold, precious metal, semi-precious metal and platinum foil;
- Laboratory delivery fees;
- Laboratory fabricated temporary crowns.
- Occlusal rehabilitations and the associated laboratory costs;
- Provisional crowns and the associated laboratory costs;

Fillings/Restorations
- Fillings to restore teeth damaged due to toothbrush abrasion, attrition, erosion and fluorosis;
- Gold foil restorations;
- Ozone therapy.
- Polishing of restorations;
- Resin bonding for restorations charged as a separate procedure to the restoration;

Hospital and Anaesthetist Claims for the following procedures will not be covered when performed under general anaesthesia
- Apicectomies;
- Conservative dental treatment (fillings, extractions and root canal therapy) in hospital for children above the age of 6 years and adults;
- Dentectomies;
- Frenectomies;
- Implantology and associated surgical procedures;
- Professional oral hygiene procedures;
- Surgical tooth exposure for orthodontic reasons.

Hospitalisation (general anaesthetic);
- Where the reason for admission to hospital is dental fear or anxiety;
- Multiple hospital admissions;
- Where the only reason for admission to hospital is to acquire a sterile facility;
- Cost of dental materials for procedures performed under general anaesthesia.

Implants
- Dolder bars and associated abutments on implants' including the laboratory cost;
- Laboratory delivery fees.

Maxillo-Facial Surgery and Oral Pathology
- Auto-transplantation of teeth;
- Closure of an oral-antral opening (item code 8909) when claimed during the same visit with impacted teeth (item codes 8941, 8643 and 8945);
- Orthognathic (jaw correction) surgery and any related hospital cost, and the associated laboratory costs.
- Sinus lift procedures;

Orthodontics
- Cost of invisible retainer material;
- Laboratory delivery fees.
- Orthodontic treatment for cosmetic reasons and associated laboratory costs;
- Orthodontic treatment for a member or dependant younger than 9 and older than 18 years of age;
- Orthodontic re-treatment and the associated laboratory costs;

Partial Metal Frame Dentures
- Cost of gold, precious metal, semi-precious metal and platinum foil;
- High impact acrylic;
- Laboratory delivery fees.
- Metal base to full dentures, including the laboratory cost;

Periodontics
- Perio chip placement.
- Surgical periodontics, which includes gingivectomies, periodontal flap surgery, tissue grafting and hemisection of a tooth for cosmetic reasons;

Plastic Dentures/Snoring Appliances/Mouthguards
- Cost of gold, precious metal, semi-precious metal and platinum foil;
- Diagnostic dentures and the associated laboratory costs;
- High impact acrylic;
- Laboratory cost associated with mouth guards (The clinical fee will be covered at the Medshield Dental Tariff where managed care protocols apply);
- Laboratory delivery fees.
- Snoring appliances and the associated laboratory costs;

Preventative Care
- Cost of prescribed toothpastes, mouthwashes (e.g. Corsodyl) and ointments;
- Fissure sealants on patients 16 years and older.
- Nutritional and tobacco counselling;
- Oral hygiene instruction;
- Oral hygiene evaluation;
- Professionally applied fluoride is limited to beneficiaries from age 5 and younger than 13 years of age;
- Tooth Whitening;

Root Canal Therapy and Extractions

- Direct and indirect pulp capping procedures.
- Root canal therapy on primary (milk) teeth;
- Dental procedures or devices which are not regarded by the relevant Managed Healthcare Programme as clinically essential or clinically desirable;
- General anaesthetics, moderate/deep sedation and hospitalisation for dental work, except in the case of patients under the age of 6 years or with bony impaction of the third molars/ impacted/ wisdom teeth;
- General anaesthetics and moderate/deep sedation in the practitioner's rooms, unless pre-authorised.

Hospitalisation

- Application for a pre-authorisation reference number (PAR) for a clinical procedure, treatment or specialised radiology is not made or is refused, no benefits are payable (refer to sections 4.1 and 4.7 of Annexure D);
- Accommodation and services provided in a geriatric hospital, old age home, frail care facility or similar institution are not payable (unless specifically provided for in Annexure B) (unless PMB level of care, then specific DSP applies);
- Frail care services shall only be considered for pre-authorisation if certified by a medical practitioner that such care is medically essential and such services are provided through a registered frail care centre or nurse;
- Hospice services shall only be paid for if provided by an accredited member of the Hospice Association of Southern Africa and if pre-authorised by a Managed Health Care Provider;
- Nursing services or frail care provided other than in a hospital shall only be available if pre-authorised by a Managed Health Care Provider.

Infertility

- Medical and surgical treatment, which is not included in the Prescribed Minimum Benefits in the Regulations to the Medical Schemes Act 131 of 1998, Annexure A, Paragraph 9, Code 902M, including:
  - Air Inflation of fallopian tubes for patency
  - Assisted Reproductive Technology (ART)
  - Cystoscopy, testicular biopsy and vasograms for male infertility
  - Donor Sperm
  - Gamete Intrafallopian tube transfer (GIFT)
  - Intra Uterine Insemination (IUI)
  - Intracytoplasmic sperm injection (ICSI)
  - In-vitro fertilization (IVF)
  - Ovarian drilling
  - Re-anastomosis of fallopian tubes
  - Zygote Intrafallopian tube transfer (ZIFT)
- Salpingostomy (reversal of tubal ligation);
- Vasovasostomy (reversal of vasectomy).

Maternity

- Caesarean Section unless clinically appropriate;
- Pregnancy scans - 3D and 4D;
- Pregnancy greater than 12 weeks from date of signed application.

Medicine and Injection Material

- Anabolic steroids and immunostimulants (unless PMB level of care, DSP applies);
- Biological Drugs, except for PMB level of care and when provided specifically in Annexure B. (DSP applies);
- Clinical trials for benefits and treatment unless pre-authorised by the relevant Managed Healthcare Programme;
- Cosmetic preparations, emollients, moisturizers, medicated or otherwise, soaps, scrubs and other cleansers, sunscreen and suntanning preparations, medicated shampoos and conditioners, except for the treatment of lice, scabies and other microbial infections and coal tar products for the treatment of psoriasis;
- Diagnostic agents, unless authorised and PMB level of care;
- Erectile dysfunction and loss of libido medical treatment (unless caused by PMB associated conditions subject to Regulation 8);
- Erythropoietin, unless PMB level of care;
- Food and nutritional supplements including baby food and special milk preparations unless PMB level of care and prescribed for malabsorptive disorders and if registered on the relevant Managed Healthcare Programme; or for mother to child transmission (MTCT) prophylaxis and if registered on the relevant Managed Healthcare Programme;
- Growth hormones, unless pre-authorised (unless PMB level of care, DSP applies);
- Imatinib mesylate (Gleevec) (unless PMB level of care, DSP applies);
- Immunoglobulins and immune stimulants, oral and parenteral, unless pre-authorised (unless PMB level of care, DSP applies);
- Injection and infusion material, unless PMB and except for outpatient parenteral treatment (OPAT) and diabetes;
- Intestinal flora medicines;
- Lucentis, Eylea and Ozurdex for the treatment of Vitreoretinal conditions, unless specifically stipulated in the Annexure B (DSP applies);
- Medicines and chemotherapeutic agents not approved by the SAHPRA (South African Health Products Regulatory Authority) unless Section 21 approval is obtained and pre-authorised by the relevant Managed Healthcare Programme;
- Medicines defined as exclusions by the relevant Managed Healthcare Programme;
- Medicines not authorised by the relevant Managed Healthcare Programme;
- Medicines not included in a prescription from a medical practitioner or other Healthcare Professional who is legally entitled to prescribe such medicines (except for schedule 0, 1 and 2 medicines supplied by a registered pharmacist);
- Medicines used specifically to treat alcohol and drug addiction. Pre-authorisation required (unless PMB level of care, DSP applies);
- Medicines, unless they form part of the public sector protocols and specifically provided for in Annexure B and are authorised by the relevant Managed Healthcare Programme:
  - Liposomal amphotericin B for fungal infections (unless PMB level of care, DSP applies);
  - Maintenance Rituximab or other monoclonal antibodies in the first line setting for haematological malignancies unless used for Diffuse large B-cell lymphoma in which event DSP applies (unless PMB level of care, DSP applies);
  - Protein C inhibitors, for septic shock and septicaemia (unless PMB level of care, DSP applies);
  - Specialised drugs that have not convincingly demonstrated a survival advantage of more than 3 months in metastatic malignancies in all organs for example sorafenib for hepatocellular carcinoma, bevacizumab for colorectal and metastatic breast cancer (unless PMB level of care, DSP applies). Avastin for the treatment of Macular Degeneration is not excluded, however DSP applies;
  - Trastuzumab for the treatment of HER2-positive early breast cancer that exceeds the dose and duration of the 9-week regimen as used in ICON protocol (unless PMB level of care, DSP applies);
  - Trastuzumab for the treatment of metastatic breast cancer (unless PMB level of care or included in the ICON protocol applicable to the member's option, DSP applies);
- Nappies and waterproof underwear;
- Oral contraception for skin conditions, parentaral and foams;
- Patent medicines, household remedies and proprietary preparations and preparations not otherwise classified;
- Slimming preparations for obesity;

- Smoking cessation and anti-smoking preparations unless pre-authorised by the relevant Managed Healthcare Programme;
- Tonics, evening primrose oil, fish liver oils, multi-vitamin preparations and/or trace elements and/or mineral combinations except for registered products that include haemotinics and products for use for:
  - Infants and pregnant mothers;
  - Malabsorption disorders;
  - HIV positive patients registered on the relevant Managed Healthcare Programme.

Mental Health
- Sleep therapy, unless provided for in the relevant benefit option.
- Psychometric assessments for education and literacy performed on beneficiaries who are 21 years or older.

Non-Surgical Procedures and Tests
- Conservative Back and Neck Treatment;
- Epilation – treatment for hair removal (excluding Ophthalmology);
- Healthcare services including scans and scopes that could be done out of hospital and for which an admission to hospital is not necessary;
- Hyperbaric oxygen therapy except for anaerobic life-threatening infections, Diagnosis Treatment Pairs (DTP) 277S and specific conditions pre-authorised by the relevant Managed Healthcare Programme and at a specific DSP;
- Investigations and diagnostic work-up unless stipulated in 3.4.6 or specified in Annexure B;
- Nail Disorders;

Optometry
- Contact lens fittings;
- Optical devices which are not regarded by the relevant Managed Healthcare Programme, as clinically essential or clinically desirable;
- Optical Management Programme exclusions as per the Schemes.
- Plano tinted and other cosmetic effect contact lenses (other than prosthetic lenses), and contact lens accessories and solutions;
- Radial Keratotomy/Excimer Laser/Intra-ocular Lens, unless otherwise indicated in the Annexure B, no benefits shall be paid. The member shall submit all relevant medical reports as may be required by the Scheme and authorised by the relevant Managed Healthcare Programme;
- Sunglasses, prescription sunglasses and related treatment lenses, example wrap-around lenses, polarised lenses and outdoor tints;

Organs, Tissue and Haemopoietic Stem Cell (Bone Marrow) Transplantation and Immunosuppressive Medication
- International donor search costs for transplants.
- Organs and haemopoietic stem cell (bone marrow) donations to any person other than to a member or dependant of a member on this Scheme;

Physical Therapy (Physiotherapy, Chiropractic's and Biokinetics)
- Biokinetics and Chiropractic's in hospital;
- Physiotherapy for mental health admissions;
- X-rays performed by Chiropractors.

Prosthesis and Devices Internal and External
- Cochlear implants (Processors speech, Microphone headset, audio input selector), auditory brain implants (lost auditory nerves due to disease) unless specifically provided for in Annexure B;
- Customised aortic stents, unless Prescribed Minimum Benefits level of care (DSP applies);
- Custom-made hip arthroplasty for inflammatory and degenerative joint disease unless authorised by the relevant Managed Healthcare Programme.
- Drug eluting stents, unless Prescribed Minimum Benefits level of care (DSP applies);
- Internal Nerve Stimulators;
- IUD's inserted in hospital (intrauterine device such as Mirena etc), if protocols/criteria has been met, the Scheme will pay at Scheme Tariff only for the device and its insertion in the practitioners' rooms. The Scheme will not be liable for theatre costs related to the insertion of the device);
- Osseo-integrated implants for dental purposes to replace missing teeth, unless specifically provided for in Annexure B or PMB specific DSP applies;
- Peripheral vascular stents, unless Prescribed Minimum Benefits level of care (DSP applies);
- TAVI procedure - transcatheter aortic-valve implantation unless authorised by the relevant Managed Healthcare Programme. The procedure and prosthesis will only be funded up to the global fee the equivalent of PMB level of care. (open Aortic valve replacement surgery);

Radiology and Radiography
- Application for a pre-authorisation reference number (PAR) for specialised radiology procedures is not made or is refused, no benefits are payable (refer to sections 4.1, 4.7.6 and 4.7.7 of Annexure D);
- Bone densitometry performed by a General Practitioner, or a Specialist not included in the Scheme credentialed list of specialities;
- Computed Tomography Coronary Angiography (CTCA) (unless PMB level of care and symptomatic, DSP applies);
- CT colonography (virtual colonoscopy) for screening (unless PMB level of care, DSP applies);
- MDCT Coronary Angiography and MDCT Coronary Angiography for screening (unless PMB level of care, DSP applies);
- MRI scans ordered by a General Practitioner, unless there is no reasonable access to a Specialist;
- PET (Positron Emission Tomography) or PET-CT for screening (unless PMB level of care, DSP applies);
- Screening that has not been pre-authorised or is not in accordance with the schemes policies and protocols.

Surgical Procedures
- Abdominoplasties and the repair of divarication of the abdominal muscles (unless PMB level of care, DSP applies);
- Arthroscopy for osteoarthritis (unless PMB level of care, DSP applies);
- Back and Neck surgery (unless PMB level of care, DSP applies);
- Balloon sinuplasty;
- Bilateral gynaecomastia;
- Blepharoplasties and Ptosis unless causing demonstrated functional visual impairment and pre-authorised (unless PMB level of care, DSP applies);
- Breast augmentation;
- Breast reconstruction of the affected side only, unless mastectomy following cancer and pre-authorised within Scheme protocols/ guidelines (unless PMB level of care, DSP applies);
- Breast reductions, Benign Breast Disease;
- Circumcision in hospital except for a newborn or child under 12 years, subject to Managed Care Protocols;
- Correction of Hallux Vulgus and Bunionectomy;
- Cosmetic treatment and surgery costs performed over and above the codes authorised for admission (unless PMB level of care, DSP applies);
- Da Vinci Robotic assisted Radical surgery, including radical prostatectomy, additional costs relating to use of the robot during such surgery, and including additional fees pertaining to theatre time, disposables and equipment fees remain excluded;
- Deep brain stimulation for Parkinson's and intractable epilepsy;
- Endoscopic Surgery and Laparoscopic Surgery unless specifically provided for in the Annexure B, section D13 - Routine Diagnostic Endoscopic Procedures only if done in Dr Rooms;
- Erectile dysfunction surgical procedures;

- Gender reassignment medical or surgical treatment;
- Genioplasties as an isolated procedure (unless PMB level of care, DSP applies);
- Joint replacement including but not limited to hips, knees, shoulders and elbows, unless PMB level of care and DSP applies;
- Keloid surgery, except following severe burn scars on the face and neck, for functional impairment such as contractures and excision of a tattoo (unless PMB level of care, DSP applies); skin disorders (life threatening / non-life threatening) including benign growths;
- Kyphoplasties and Vertebroplasties, unless authorised and subject to Managed Care Protocols;
- Laparoscopic unilateral primary inguinal hernia repair (unless specifically authorised by the managed care organisation);
- Nasal treatment or surgery including but not limited to septoplasties, osteotomies and nasal tip surgery functional nasal problems and functional sinus problems;
- Obesity - surgical treatment and all related procedures e.g. bariatric surgery, gastric bypass surgery and other procedures (unless PMB and PMB level of care, strict criteria and DSP applies/ global fee, a Proventi or South African Society for Surgery, Obesity and Metabolism (SASSO) accredited Centre of Excellence site, and by a Proventi or SASSO accredited surgeon.);
- Otoplasty, pre-authorisation will only be considered for otoplasty performed on beneficiaries who are under the age of 13 years upon submission of a medical motivation and approval by the Scheme. No benefit is available for otoplasty for any beneficiary who is 13 years or older;
- Pectus excavatum / carinatum (unless PMB level of care, DSP applies);
- Portwine stain management, subject to application and approval, laser treatment will be covered for portwine stains on the face of a beneficiary who is 2 years or younger;
- Prophylactic Mastectomy (unless PMB level of care, DSP applies);
- Refractive surgery, unless specifically provided for in Annexure B;
- Revision of scars, except following burns and for functional impairment (unless PMB level of care, DSP applies);
- Rhinoplasties for cosmetic purposes (unless PMB level of care, DSP applies);
- Rhizotomies and Facet Pain Blocks;
- Robotic surgery, other than for radical prostatectomy where specifically authorised by the managed care organisation, strict criteria and protocols (global fee applies); additional costs relating to the use of the robot during such preauthorised surgery, and including additional fees pertaining to theatre time, disposables and equipment fees remain excluded;
- Prosthesis for spinal procedures paid up to the value of PMB level of care, where applicable;
- Surgery for oesophageal reflux and hiatus hernia (unless PMB level of care, DSP applies);
- Uvulo palatal pharyngoplasty (UPPP and LAUP) (unless PMB level of care, DSP applies);
- Varicose veins, surgical and medical management (unless PMB level of care, DSP applies).

NOTES

NOTES

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medical scheme
Partner for Life

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- MediValue
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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. Pending CMS approval. October 2024.
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