Herewith attached are the 2019 PSG Wealth product enhancements and changes for Discovery including Health, Vitality, PrimaryCare and Gap Cover.

## 1. What to consider when making changes this medical aid season

The change of seasons coincides with the time when Medical Schemes announce their benefit changes for the following year. It is tempting to speed through the process of selecting a medical aid option for the year ahead, but you need to consider how your circumstances and health have changed and whether your current option is still appropriate for you.

## 2. Look beyond the contribution

Combined with the fact that Medical aid costs are escalating faster than inflation, tough economic times make it tempting to choose the least costly option. The average increase announced by Medical Schemes in the year thus far is between 7% and 9%, compared to inflation of around 5.1%. Many medical aids are responding by not increasing some benefits (like oncology) in line with these rising costs. Therefore, be sure to look at any benefit changes and compare exclusions. You could save a small amount each month by selecting a cheaper option, but then end up having more out-of-pocket medical expenses.

## 3. Select an option that suits your needs

The cost of a single GP visit can set you back R500 in consultation fees, excluding the costs of any medication. If you selected a hospital plan when you were young and single, and have not changed your plan since then, you may be long overdue for a detailed review. Most people think they will be able to fund the costs of an occasional doctor's visit themselves. However, when you get seriously ill, require an out of hospital procedure or when multiple family members get sick at the same time, you could have to fund medical costs from credit. If you are not a member of a medical aid at all, the consequences could be even more devastating.

## 4. How do you choose the right plan?

The main determinant should be your medical needs, so it is necessary to have a good understanding of what benefits and services are covered by which options and on which medical schemes. Affordability is an important piece of the puzzle when it comes to selecting the right fit - but it should not be the only consideration.

## 5. Medical aid 101

You need to understand some basic terminology to help you choose a plan. If in any doubt, it is best to consult a medical aid consultant or broker - providing guidance on the right option is part of their job and this does not come at an additional cost to you.

1. Most medical aids will cover in-hospital costs (this is when you are admitted to hospital) within certain limits. This does not mean, however, that they cover all the

costs of being in the hospital. Some doctors charge higher fees than what the medical aid has agreed to pay, or they do not pay for all equipment/treatments fully.
2. All members are covered for Prescribed Minimum Benefits (PMBs) - 26 conditions identified by law. Most of the common chronic illnesses (e.g. asthma, diabetes) are covered via PMBs.
3. Beyond this, the detail will depend on your specific option selected.
4. Most schemes cover additional chronic diseases on their more comprehensive options, so it will be worthwhile investigating which options, on which schemes, provide the cover you require.
5. Medical aid may limit what they pay in the case of serious illnesses, like cancer, mental illness or for example pregnancy. In the first case, they may not pay for certain drugs, and in the latter case, they could only pay for a certain number of scans and doctors' visits.
6. Be sure to check how your plan handles out-of-hospital procedures. These are minor procedures that do not require you to stay in the hospital overnight and therefore they are not covered under in-hospital costs.
7. Day-to-day benefits cover the other expenses typically covered in terms of any of the other categories, for example for GP consultations, medication, optometry, radiology and pathology.

## 6. There are three basic types of schemes

The benefits available will be structured in terms of the type of plan, or option you select.

1. Traditional schemes set various annual sub-limits for day-to-day benefits. If a sub-limit is exhausted, the member must fund further services for that benefit category from their own pocket. Sub-limits not used during the year fall away at the end of the year, and member's access the refreshed annual sub-limit set for the following year.
2. New generation schemes fund day-to-day benefits from a medical savings account which is funded from a portion of the monthly contribution (up to a maximum of 25%), on an up-front basis (i.e. the scheme makes available the full allocated savings account from the beginning of the year even though this is only funded in monthly increments by the member). There is usually no prescription as to how or in what proportions services may be funded from the savings account but, once depleted, members have to pay from their pockets for further day-to-day services. Savings are not used accumulate from year to year.
3. Schemes offering a combination of the above two approaches are called hybrid schemes.

## And there's more...

There are many schemes out there, with many underlying options available. Some additional permutations you may encounter on new generation schemes include network and threshold plans. Network plans restrict which GP and hospitals you can use, in an effort to keep costs low. Threshold plans make additional savings available once costs have

moved above a certain level, but the member must fund the payment `gap' until the payment is reached.

**Now is your chance to review your choice**

Members of all schemes have an annual opportunity to change benefit options. Many employers restrict the choice of fund, but if you are considering changing schemes, be sure to clarify whether any waiting periods would apply before making the leap.

**Think of the bigger picture to make the right choice**

Take the time to engage with your medical fund choices and apply your mind when selecting your option this year. The right choice for you is the one that suits your lifestyle, your needs and your pocket. Most importantly, remember that your health impacts your ability to earn a living and enjoy your life. Pause to see the bigger picture before you `tick the box' on that medical aid form.

## 7. Medical Gap Cover - Don't get caught by out of pocket

If you do not have a gap cover policy, you might want to consider taking out a Medical Gap Cover. Medical gap cover helps pay hospital bills that aren't fully covered by your medical aid in South Africa. It's not a medical aid but rather insurance that covers you in the event that your medical aid doesn't cover all your costs.

**HOW DOES GAP COVER WORK?**

**Medical aid gap cover helps you pay the shortfall on those medical expenses not fully covered by your medical aid.**

Doctors can charge up to 5 times medical aid rates, and some specialist procedures require a co-payment, which your medical aid might not cover in full. This means that you will need to pay the difference, the gap, out of pocket.

**WHAT DOES GAP COVER PAY FOR?**

**Gap cover pays for in-hospital and some out-of-hospital medical expenses that are not fully covered by your medical aid.**

You receive a total cover amount per person, per year, so that if you are admitted to hospital or have to go for tests or procedures out-of-hospital, you will be able to pay the costs not covered by your medical aid.

Please contact your allocated Healthcare Account Manager for more information on Gap Cover, and the appropriate medical aid plan for 2019 - Tel: +27 (86) 166 2346