Threshold Benefit

The Threshold Benefit pays for members' day-to-day expenses once claims have accumulated up to the required level. Here's how the benefit works on the different Fedhealth options.

1. On maxima PLUS, maxima EXEC and flexiFED 4

To calculate your Threshold Level on maxima PLUS, maxima EXEC and flexiFED 4, refer to the tables below:

ANNUAL THRESHOLD LEVELS		
	maxima PLUS	**maxima EXEC**
Member	R20 800	R18 100
Adult dependant	R16 200	R13 800
Child dependant*	R5 600	R4 700

	flexiFED 4
M	R18 500
M + 1	R33 700
M + 2	R38 200
M + 2+	R42 700

Your Threshold Level is reached through the accumulation of your claims paid from your day-to-day benefit and your own pocket, throughout the year at the Fedhealth Rate.

Where limits apply, expenses will only accumulate up to this limit, and this limit will also apply to refunds from Threshold. However, further claims will be paid if you have funds available in your Savings Account. **See the table below for detail on these accumulation limits.**

The self-payment gap

It may happen that your Savings have been depleted before the required Threshold Level has been reached. This is referred to as a self-payment gap. You will now continue to pay for day-to-day expenses from your own pocket. To close this self-payment gap, you need to continue submitting these expenses to Fedhealth. These claims will not be refunded but will accumulate towards your Threshold Level. (Please refer to previous point for detail on accumulation limits).

Once you've reached the required Threshold Level, your day-to-day expenses will be refunded from the Threshold Benefit. Some of your day-to-day expenses will be covered unlimited except for appliances, additional medical services (which include consultations with psychiatrists), advanced dentistry, maternity (2D antenatal scans), optometry and prescribed medication for which only the remainder of the annual limit will apply. For example, if a family spends R13 000 on prescribed medication, a maximum of R12 770 (set sub-limit) will accumulate to their Threshold Level. Once this family is in Threshold, they will have no further prescribed medication benefit.

Example of calculating the Threshold Level:

Example for a member with 1 adult dependant and 2 child dependants who joins flexiFED 4 on 1 January. The Threshold Level is calculated as follows:

M +2+	R42 700

When out-of-hospital costs exceed R42 700 for this family, the Threshold Benefit kicks in.

If a member joins after 1 January, the Threshold level is calculated from the date that they join. However, the minimum Threshold Level is based on three months' membership.

Examples of pro-rated Threshold Level calculations for a member with 1 adult dependant and 2 child dependants are as follows:

1. If the member joins on 1 May, the Threshold Level will be calculated for 8 months.
   R42 700 x 8/12 = R28 476
2. If the member joins 1 November, the Threshold level will be calculated for 3 months even though only 2 months of the year remain. R42 700 x 3/12 = R10 675

The Threshold Benefit offers an unlimited benefit for the following expenses once the Threshold Level has been reached:

- Non-network GPs (non-network GPs will not be covered from the Threshold Benefit on maxima **EXEC**)
- Specialists
- Basic dentistry
- General radiology
- Pathology

The following expenses do not accumulate to and will not be refunded from the Threshold Benefit:

- Homeopaths and naturopaths, including medication
- Over-the-counter medication
- Over-the-counter spectacles
- Frail care expenses
- MEL medication
- All Scheme exclusions

On maxima EXEC and flexiFED 4, the following expenses do not accumulate to Threshold, but will be refunded from the Threshold Benefit:

- Appliances, external accessories and orthotics
- Additional medical services including psychiatrists (network and non-network)

The following expenses are limited when accumulating to Threshold and once Threshold is reached:

ANNUAL THRESHOLD LEVELS			
Appliances	**maxima PLUS**	**maxima EXEC**	**flexiFED 4**
Per family	R17 300	R17 300	R12 900
Additional medical services			
Per family	R19 400	R19 400	R12 900
Prescribed medication			
Per beneficiary	R11 060	R7 940	R6 330
Per family	R22 010	R14 700	R12 770
Advanced dentistry			
Per beneficiary	R8 270	R8 270	R8 270
Per family	R24 700	R24 700	R24 700
Optometry			
Per beneficiary	R3 740	R3 740	R3 740
Per family	R11 400	R11 400	R11 400

- These limits apply once only, before and/ or after, reaching the Threshold Level, depending on how much of the limit has accumulated.
- If the member joins after 1 January, all limits are reduced proportionately each month for the calendar year to a minimum of 25%.

Examples of how limits in the above table apply before and after the Threshold Level is reached:

1. **Before the Threshold Level is reached:**

   If a dependant claims R7 000 for prescribed medication, the R6 330 will accumulate towards the Threshold Level and no further benefit for prescribed medication is available for this dependant – even if the Threshold is reached.

2. **After the Threshold Level is reached:**

   If a family has reached the Threshold Level and has not claimed for prescribed medication, the full R12 770 for the family will be available from the Threshold Benefit for prescribed medication.

3. **Before and after the Threshold Level is reached:**

   If a family has claimed R7 000 for prescribed medication before the Threshold Level is reached, a balance of R5 770 will be available from the Threshold Benefit for prescribed medication.

How do claims accumulate to the Threshold Level?

Claims that are paid from the Day-to-day Benefit (OHEB, Savings and Wallet) accumulate at the Fedhealth Rate according to certain limits. If claims have been paid by the member, they must be submitted to Fedhealth to accumulate towards the Threshold Level. Self-payment gaps will occur if the refund of your claim is greater than the amount that accumulates to Threshold.

How is the Threshold Level reached?

Once the total of the claims that have accumulated reach the predetermined amount of the Threshold Level, the Threshold Benefit commences and claims are processed from this benefit in terms of the rules.

What the Threshold covers

All out-of-hospital claims until the end of December of that year are covered. Prescribed medication is covered at MPL (Medicine Price List). There is a co-payment in Threshold on the following options: maxima **EXEC** – 10%, flexi**FED 4** – 20%. This means that the Scheme will refund up to 80% of the Fedhealth Rate for claims refunded from the Threshold Benefit on flexi**FED 4**, and 90% of the Fedhealth Rate for claims refunded from the Threshold Benefit on maxima **EXEC**.

It's important to submit all claims whether they are paid from Day-to-day Benefits (the Savings Account, Wallet or OHEB) or not, so that they can accumulate towards the Threshold Level.

2. On flexiFED 1, flexiFED 2 and flexiFED 3

The Threshold Benefit is also available on the flexi**FED 1** (and **Elect**), flexi**FED 2** (and **GRID** and **Elect**) and flexi**FED 3** (and **GRID** and **Elect**) options.

During the year, all day-to-day claims on these options accumulate to the Threshold Level at cost. If your day-to-day claims reach this level, you unlock the Threshold benefits, namely dentistry and unlimited network General Practitioner (GP) visit benefits that the Scheme covers from Risk.

1. Unlimited network GP visits

Once your day-to-day claims have accumulated to the Threshold Level, your unlimited network GP benefit kicks in. However, in order for you to use this benefit, you must nominate a network GP for each member of the family on your membership.

How it works

If you use a GP in the Fedhealth network, your consultation is firstly paid out of the current year's Savings Account. If your Savings Account has run out, you can transfer funds from your MediVault to your Wallet and these funds can then be used to cover these costs. If you don't transfer funds from your MediVault to your Wallet, you will have to cover these costs from your own pocket.

When your day-to-day claims have accumulated to your Threshold Level, GP consultations are paid out of the Threshold Benefit. This covers the consultation only. To find a GP in the Fedhealth network, go to our website or the Fedhealth Family Room or call **0860 002 153**. The Theshold Benefit gives unlimited cover for GP consultations, as long as you use a GP who is in the Fedhealth network. You must however nominate a GP in the Fedhealth GP network in order for your GP consultations to be paid from the Threshold Benefit once your day-to-day claims have accumulated to your Threshold Level.

Non-nominated GPs

A limited benefit applies to using non-nominated GPs: you get two visits per beneficiary per year at a network GP. Once this benefit has been used, the Scheme will not pay for any visits to non-nominated network GPs from the Threshold Benefit and you will have to pay for them from your own pocket. Please note that a maximum of two mental health GP consultations per beneficiary per year will be covered from the Threshold Benefit.

How to nominate a GP

Each person on your medical aid can nominate up to two different GPs, but must use these GPs for all consultations. Please phone the Fedhealth Customer Contact Centre on **0860 002 153** to nominate up to two different GPs for each person on your medical aid. You will be allowed to change GPs every six months. This means that you always have unlimited cover for GPs, as long as you nominate and use a GP in the Fedhealth network.

2. Basic dentistry benefit

flexiFED 2 and flexiFED 3

Basic dentistry, which includes removal of teeth and roots, suturing of traumatic wounds as well as oral medical procedures, is covered from the Savings Account. If your Savings Account has run out, you can transfer funds from your MediVault to your Wallet, to cover these costs. If you don't transfer funds from your MediVault to your Wallet, you will have to cover these costs from your own pocket.

When your day-to-day claims have accumulated to your Threshold Level, basic dentistry is paid out of the Threshold Benefit. The basic dentistry benefit covers two annual consultations per beneficiary including x-rays, scaling & polishing, fillings, extractions and root canal. It is subject to a contracted list of dentists and limited to a list of approved procedures, dental tariff codes and protocols. Plastic dentures limited to one set per beneficiary every two years.

Dental codes for flexiFED 2 and 3

CODE	CODE DESCRIPTION	LIMITATIONS
8101	Consultation	2 per beneficiary per year
8104	Examination for a specific problem not requiring full mouth examination	1 per beneficiary per year
8107/8112	Intra oral radiographs, per film	Maximum of two per beneficiary per year
8159	Scaling and polishing	2 per beneficiary per year
8161	Topical application of fluoride	Between the ages of 3-12 years. 2 per beneficiary per year
8163	Fissure sealant, per tooth	Patients younger than 14; maximum of 8 per year; 2 per quadrant
8341	Amalgam one surface	Any four amalgam fillings per beneficiary per year
8342	Amalgam two surfaces	
8343	Amalgam three surfaces	
8344	Amalgam four and more surfaces	
8351	Resin restoration, one surface anterior	Any four resin fillings per beneficiary per year (anterior)
8352	Resin restoration, two surface anterior	
8353	Resin restoration, three surface anterior	
8354	Resin restoration, four and more surfaces	
8367	Resin restoration, one surface posterior	Any four resin fillings per beneficiary per year (posterior)
8368	Resin restoration, two surface posterior	
8369	Resin restoration, three surface posterior	
8370	Resin restoration, four and more surfaces	
8307	Amputation of pulp (pulpotomy)	Only on primary teeth
8132	Root canal therapy - gross pulpal debridement	1 per beneficiary per year
8201	Extraction, single tooth. Code 8201 is charged for the first extraction in a quadrant	Any 4 non-surgical extractions per beneficiary per year
8202	Extraction, each add tooth. Code 8202 is charged for each additional extraction in the same quadrant	
8937	Surgical removal of tooth	Quantity limit of 4, restricted to posterior permanent teeth
8935	Treatment of septic socket	1 per beneficiary per year
8109	Infection control / barrier techniques. Code 8109 includes the provision by the dentist of new rubber gloves, masks, etc for each patient	4 per year, 2 per visit
8110	Sterilised instrumentation	2 per year, 1 per visit
8145	Local anaesthetic	2 per year, 1 per visit
8231	Complete dentures – maxillary and mandibular	1 (one) set of dentures allowed per beneficiary per 24 months ONLY members and beneficiaries over the age of 21 years No metal base to complete or partial dentures allowed
8232	Complete dentures – maxillary or mandibular	
8233	Partial denture (resin base) - one tooth	
8234	Partial denture (resin base) - two teeth	
8235	Partial denture (resin base) - three teeth	
8236	Partial denture (resin base) - four teeth	
8237	Partial denture (resin base) - five teeth	
8238	Partial denture (resin base) - six teeth	
8239	Partial denture (resin base) - seven teeth	
8240	Partial denture (resin base) - eight teeth	
8241	Partial denture (resin base) - nine teeth and more	
8259	Rebase complete or partial dentures (Lab)	
8269	Repair denture	
8263	Reline complete or partial dentures (chair side)	
8271	Add tooth to existing partial dentures	
8273	Impression to repair / addition	
8140	Fee for treatment at a venue	Only if clinically indicated & authorised

flexiFED 1

Basic preventative dentistry, which includes X-rays and scaling and polishing, is covered from the Savings Account. If your Savings Account has run out, you can transfer funds from your MediVault to your Wallet to cover these costs. If you don't transfer funds from your MediVault to your Wallet, you will have to cover these costs from your own pocket.

When your day-to-day claims have accumulated to your Threshold Level, preventative dentistry is paid out of the Threshold Benefit. The preventative dentistry benefit covers two annual consultations per beneficiary including scaling and polishing. These consultations are subject to a contracted list of dentists and limited to a list of approved procedures, dental tariff codes and protocols.

Dental codes for flexiFED 1

Code	Code Description	Limitations
8101	Consultation	2 per beneficiary per year
8107/8112	Intra oral radiographs, per film	Maximum of two per beneficiary per year
8109	Infection control / barrier techniques. Code 8109 includes the provision by the dentist of new rubber gloves, masks, etc. for each patient	4 per year: 2 per visit
8110	Sterilized instrumentation	2 per year: 1 per visit
8159	Scaling and polishing	2 per beneficiary per year
8161	Topical application of fluoride	Between the ages of 3-12 years 2 per beneficiary per year
8163	Fissure sealant, per tooth	Patients younger than 14; maximum of 8 per year; 2 per quadrant

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CONTACT DETAILS

For more information, please visit fedhealth.co.za, or use the Fedhealth Family Room, WhatsApp service or Fedhealth Member App. You can also call the Fedhealth Customer Contact Centre on 0860 002 153.

Disease Management	Europ Assistance	MVA Third Party Recovery Department	Fedhealth Baby
0860 101 306	0860 333 432	012 431 9718	0861 116 016

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