SIZWE HOSMED
MEDICAL SCHEME
Your choice for quality care

MEMBER BENEFIT GUIDE **2023**

VALUE PROPOSITION

Financially sound with strong reserving levels	Competitive child rate until age of 26. Proof of registration required	Plans structured to suit your healthcare needs
Well structured day to day benefits	SIMPLICITY	Family friendly contributions
Comprehensive wellness and chronic care	Baby care for our new arrivals	National Footprint

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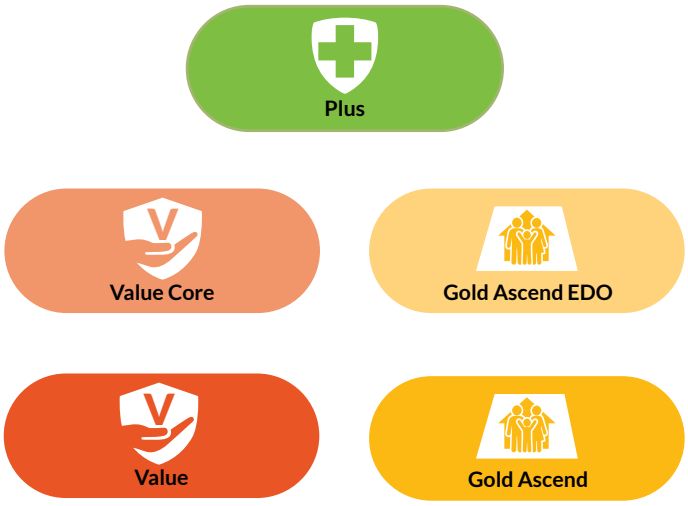
Embracing
"Your Choice for Quality Care"

THE SIZWE HOSMED PLAN STRUCTURES

Traditional Plans



A traditional plan provides day-to-day benefits that have an allocated Rand amount for each condition or treatment and may increase based on your family size. This means you have a set amount for each benefit, and once used up, you can no longer access this benefit until the new year.

These plans offer for the most part, free choice of service provider and, peace of mind that should one of your benefit conditions be fully used, you may still have other benefits available for the family and are not left with no cover at all. If you don't use these benefits during the year, they do not accumulate or carry over to the following year, instead these benefits become available at the beginning of each year.

New Generation Savings Plans

A savings plan provides you with a set rand amount (based on a % of your total contribution) allocated to what is called a members savings account (MSA) on an annual basis. Sizwe Hosmed members can choose to have either 15% or 25% of their monthly contribution set aside towards their MSA.

Your MSA is used for the families out-of-hospital (day-to-day) healthcare needs while the Scheme will also offer additional specific, out of hospital benefits so as to help preserve your MSA. The MSA is yours and unused funds will accumulate year on year, may be transferred to another savings type plan or, should you resign a savings type plan, any unused funds will be refunded to you after a period of 4 months.

In the case of the Sizwe Hosmed Access Saver Plan, the Scheme will cover the following out of hospital benefits, which means that these will not come from your own MSA account. This is a great offering for you and your family.

Out of Hospital benefits covered by the Scheme

- Basic optometry
- Basic dentistry
- Annual Wellness and screening tests
- Maternity benefits for mum

Comprehensive Plans

Titanium Executive

Platinum Enhanced

Platinum Enhanced EDO

These hybrid plans combine the best of both traditional and new generation savings plans. These plans go further to offer you peace of mind in that should your MSA become fully utilised, a small self-funded gap applies, and then the scheme steps in with additional benefits for you. Unused Member savings will carry forward each year and should you resign from a savings type plan, after 4 months unused MSA is refunded to you.

These plans are well-suited to large families who are looking for the security of comprehensive in and out of hospital cover while keeping flexibility and peace of mind that an above threshold benefit (ATB) is available in time of need.

In the case of the Sizwe Hosmed comprehensive plans, the Scheme will cover the following out of hospital benefits, which means that these will not come from your own MSA account and effectively extends the value of benefits available to your family.

Out of Hospital Scheme Risk benefits covered by the Scheme

- Basic optometry
- Basic dentistry
- Annual Wellness and screening tests
- Maternity benefits for mum

"Your Choice for Quality Care"

CONTRIBUTIONS EFFECTIVE 01 JANUARY 2023

	ESSENTIAL COPPER	ESSENTIAL COPPER	ESSENTIAL COPPER	SILVER HOSPITAL	ACCESS SAVER-25	ACCESS SAVER-15
Monthly Income	R0 -R8 500	R8 501 -R13 000	R13 001+	R0+	R0+	R0+
Member	R1 590	R1 905	R2 415	R2 040	R2 715	R2 395
Adult	R1 590	R1 905	R2 415	R1 755	R2 340	R2 065
Child*	R550	R705	R720	R405	R540	R475

* Member pays for the first three children only

GOLD ASCEND	GOLD ASCEND EDO	VALUE	VALUE CORE EDO	PLATINUM ENHANCED	PLATINUM ENHANCED EDO	PLUS	TITANIUM EXECUTIVE
R0+	R0+	R0+	R0+	R0+	R0+	R0+	R0+
R3 000	R2 850	R3 895	R3 585	R4 130	R3 925	R6 370	R7 320
R2 880	R2 735	R3 740	R3 440	R3 950	R3 755	R6 075	R6 645
R824	R785	R740	R680	R1050	R1 000	R1 190	R1 495

* Member pays for the first three children only

SALGA 40% CONTRIBUTIONS EFFECTIVE 01 JANUARY 2023

	ESSENTIAL COPPER	ESSENTIAL COPPER	ESSENTIAL COPPER	SILVER HOSPITAL	ACCESS SAVER-25	ACCESS SAVER-15
Monthly Income	R0 -R8 500	R8 501 -R13 000	R13 001+	R0+	R0+	R0+
Member	R636	R762	R966	R816	R1 086	R958
Adult	R636	R762	R966	R702	R936	R826
Child*	R220	R282	R288	R162	R216	R190

* Member pays for the first three children only

GOLD ASCEND	GOLD ASCEND EDO	VALUE	VALUE CORE EDO	PLATINUM ENHANCED	PLATINUM ENHANCED EDO	PLUS	TITANIUM EXECUTIVE
R0+	R0+	R0+	R0+	R0+	R0+	R0+	R0+
R1 200	R1 140	R1 558	R1 434	R1 625	R1 570	R2 548	R2 928
R1 152	R1 094	R1 496	R1 376	R1 580	R1 502	R2 340	R2 658
R330	R314	R296	R272	R420	R400	R476	R598

* Member pays for the first three children only

PRODUCT OFFERING FOR 2023

Essential Copper	Silver Hospital	Access Saver	Gold Ascend and Gold Ascend EDO
In Hospital Benefit No Overall Annual Limit Limited to PMB conditions only Voluntary use of non-DSP* hospital will result in a 10% co-payment PMB benefits subject to DSP	**In Hospital Benefit** No Overall Annual Limit Voluntary use of non-DSP* hospital will result in a 10% co-payment	**In Hospital Benefit** No Overall Annual Limit Voluntary use of non-DSP* hospital will result in a 10% co-payment	**In Hospital Benefit** No Overall Annual Limit NOTE: Members on the EDO Option - Network Hospital DSP applies. 10% co-payment applies to voluntary use of non DSP providers
Out of Hospital Benefits GP & Specialists consultations, Pathology, Radiology and Chronic Medicine are limited to PMBs	**Out of Hospital Benefits** PMB conditions applicable. Maternity and wellness benefits provided	**Out of Hospital Benefits** Out of Hospital benefits including GP & Specialists consultations, Pathology, Radiology, Non CDL Chronic Medicine are collectively paid from MSA.	**Out of Hospital Benefits** Day to Day benefit (Includes GP, Specialist (excluding Psychiatrists), Physiotherapy, Radiology, Pathology and Acute Medication Separate, additional benefits for alternative services, appliances, psychiatrists, maternity and wellness
		25% Contribution Annual Member Savings Account: Member = R8 160 Adult = R7 020 Child = R1 620 Out of hospital subject to sub limits and MSA* No Overall Annual Limit **15% Contribution Annual Member Savings Account:** Member = R4 320 Adult = R3 720 Child = R840 Out of hospital subject to sub limits and MSA*	**Day to Day Benefits** M - R6 884 M+1 - R10 194 M+2 - R11 930 M+3 - R13 643 M+4 - R15 377 M+5 - R17 101 M+6 - R18 814 Benefit for 27 PMB chronic conditions
Statutory Prescribed Minimum Benefits (PMBs) Unlimited			
Emergency medical cover whilst traveling outside of South Africa 100% of Scheme rates payable in RSA currency. Subject to completion of documentation prior to leaving RSA.			

Scheme benefit for 27 PMB Chronic conditions, Optical, Basic Dentistry, Maternity and Wellness &Preventative Care

Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
Scheme benefit for 27 PMB Chronic conditions, Optical, Basic Dentistry, Maternity and Wellness &Preventative Care			
In Hospital Benefit No Overall Annual Limit NOTE: Members on the CORE Option - Network Hospital DSP applies. 10% co-payment applies to voluntary use of non DSP providers	**In Hospital Benefit** No Overall Annual Limit NOTE: Members on the EDO Option - Network Hospital DSP applies. 10% co-payment applies to voluntary use of non DSP providers	**In Hospital Benefit** No Overall Annual Limit and payment at 200% of Scheme rate	**In Hospital Benefit** No Overall Annual Limit and payment at 300% of Scheme rate
Out of Hospital Benefits Out of Hospital benefits other than GP & Specialists consultations, Pathology, Radiology and Chronic Medicine are collectively limited to per Family per annum: GP consultations 20 visits per family, limited to 10 visits per beneficiary	**Out of Hospital Benefits** Subject to MSA, Self Payment Gap and Above Threshold Benefit	**Out of Hospital Benefits** Out of Hospital benefits other than GP and Specialists consultations, Pathology, Radiology and Chronic Medicine are collectively Limited to per Family per annum: GP consultations 26 visits per family, limited to 16 visits per beneficiary	**Out of Hospital Benefits** Subject to MSA, Self Payment Gap and Above Threshold Benefit
Out of Hospital Benefits M - R 10 815 M+1 - R 22 838 M+2 - R 24 843 M+3 - R 27 521 Benefit for 27 PMB chronic conditions Benefit for an additional 18 Non CDL chronic conditions **Chronic Medication Benefit** R 15 246 per family, limited to R 7 560 per beneficiary, per annum	Benefit for 27 PMB chronic conditions Benefit for an additional 26 Non CDL chronic conditions **Chronic Medication Benefit** R 15 246 per family, limited to R 7 560 per beneficiary, per annum	**Out of Hospital Benefits** M - R 13 944 M+1 - R 29 379 M+2 - R 32 067 M+3 - R 35 312 Benefit for 27 PMB chronic conditions Benefit for an additional 25 Non CDL chronic conditions **Chronic Medication Benefit** R 30 676 per family, limited to R 16 044 per beneficiary, per annum	Benefit for 27 PMB chronic conditions Benefit for an additional 35 Non CDL chronic conditions **Chronic Medication Benefit** R 30 676 per family, limited to R 16 044 per beneficiary, per annum
Statutory Prescribed Minimum Benefits (PMBs) Unlimited			
Emergency medical cover whilst traveling outside of South Africa 100% of Scheme rates payable in RSA currency. Subject to completion of documentation prior to leaving RSA.			

IN HOSPITAL BENEFITS

	Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
1. Hospital, Hospital related Benefits, and Major Medical Expenses				
1.01. Hospital admissions: Unlimited benefits for Prescribed Minimum Benefit conditions, subject to PMB legislation and regulations. All hospital admissions (including PMBs) are subject to pre-authorisation and case management protocols. In case of emergency admissions, the Scheme must be notified within 48 hours of admission. Failure to pre-authorise or notify the scheme of an admission within 48 hours will result in non-payment of claims. Essential Copper, Silver Hospital, Access Saver, Gold Ascend EDO, Value Core, Platinum Enhanced EDO, hospital benefits are only available at the Designated Service Providers. Voluntary use of non-DSP* hospital will result in 10% co-payment.				
1.01.1 Admission in Intensive and High Care unit and General Ward, as well as Theatre and Recovery Room	100% of DSP Tariff* Limited to PMBs	100% of Negotiated Tariff*	100% of DSP Tariff* Non-PMB benefits subject to availability of benefits	100% of Negotiated Tariff*
1.02. Medicines items and Pharmaceutical Products used whilst in-hospital, including TTO: Subject to PMB, medicine formulary* and the use of pharmacy network				
Medicines and consumables used in hospital and theatre Medicine to take home after discharge (TTO), paid from hospital benefit if given to the patient before being discharged. Subject to formulary* and the use of pharmacy network.	100% Negotiated Tariff * Limited to 7 days medicine supply. Paid from Hospital benefit	100% Negotiated Tariff * Limited to 7 days medicine supply. Paid from Hospital benefit	100% Negotiated Tariff * Limited to 7 days medicine supply. Paid from Hospital benefit	100% of Negotiated Tariff* Limited to 7 days medicine supply. Paid from Hospital benefit
1.03. In-hospital General Practitioner and Specialist services: Subject to PMB and case management protocols. All procedures must be pre-authorised. Failure to pre-authorise or to notify the scheme of an admission within 48 hours will result in non-payment of claims.				
1.03.1. Consultations and procedures	100% of Negotiated Tariff* Limited to PMBs	100% of Negotiated Tariff*	100% of Negotiated Tariff*	100% of Negotiated Tariff*
1.04. In-Hospital Radiology and Pathology. All Advanced/Specialised Radiology (such as CT, PET, MUGA and MRI scans), as well as Radio-isotope studies; require special authorisation and specialist referral. Failure to preauthorise would result in non-payment of claims.				
1.04.1. Basic Radiology and Pathology in-hospital	100% of Scheme Tariff	100% of Scheme Tariff	100% of Scheme Tariff Unlimited	100% of Scheme Tariff*. Subject to Pre- authorisation, Hospital Benefit Management Programme, Disease Management Programme and PMB protocols.
1.04.2. Advanced Radiology: Joint benefit In and Out of Hospital Subject to pre-authorisation and specialist referral.	SPECIALISED RADIOLOGY: Limited to 2 scans per beneficiary per annum. Limited to PMBs	SPECIALISED RADIOLOGY: Subject to a combined in-hospital and Out of hospital limit of R30 641 per family per year INTERVENTIONAL RADIOLOGY: Payable from the overall hospital benefit	SPECIALISED RADIOLOGY: MRI/PET/CAT Scans limited to 2 scans per beneficiary per annum 10% co-payment is applicable for non-PMBs MRI and CT scans	SPECIALISED RADIOLOGY: (MRI/CAT scan/ Angiogram) subject to an overall combined in and out of hospital limit of R22 654 per family per annum, pre-authorisation and managed care protocols INTERVENTIONAL RADIOLOGY: Within hospital limit, subject to pre- authorisation and clinical protocols

IN HOSPITAL BENEFITS

	Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
1. Hospital, Hospital related Benefits, and Major Medical Expenses				
1.01. Hospital admissions: Unlimited benefits for Prescribed Minimum Benefit conditions, subject to PMB legislation and regulations. All hospital admissions (including PMBs) are subject to pre-authorisation and case management protocols. In case of emergency admissions, the Scheme must be notified within 48 hours of admission. Failure to pre-authorise or notify the scheme of an admission within 48 hours will result in non-payment of claims. Essential Copper, Silver Hospital, Access Saver, Gold Ascend EDO, Value Core, Platinum Enhanced EDO, hospital benefits are only available at the Designated Service Providers. Voluntary use of non-DSP* hospital will result in 10% co-payment.				
1.01.1 Admission in Intensive and High Care unit and General Ward, as well as Theatre and Recovery Room	100% of Negotiated Tariff*	100% of Negotiated Tariff*	100% of Negotiated Tariff*	100% of Negotiated Tariff*
1.02. Medicines items and Pharmaceutical Products used whilst in-hospital, including TTO: Subject to PMB, medicine formulary* and the use of pharmacy network				
Medicines and consumables used in hospital and theatre	100% Negotiated Tariff *	100% Negotiated Tariff *	100% Negotiated Tariff *	100% of Negotiated Tariff*
Medicine to take home after discharge (TTO), paid from hospital benefit if given to the patient before being discharged. Subject to formulary* and the use of pharmacy network.	Medicines given to a patient to take home Limited to 7 days medicine supply. Paid from Hospital benefit	Medicines given to a patient to take home Limited to 7 days medicine supply. Paid from Hospital benefit	Medicines given to a patient to take home Limited to 7 days medicine supply. Paid from Hospital benefit	Medicines given to a patient to take home Limited to 7 days medicine supply. Paid from Hospital benefit
1.03. In-hospital General Practitioner and Specialist services: Subject to PMB and case management protocols. All procedures must be pre-authorised. Failure to pre-authorise or to notify the scheme of an admission within 48 hours will result in non-payment of claims.				
1.03.1. Consultations and procedures	100% of Negotiated Tariff*	100% of Negotiated Tariff*	200% of Negotiated Tariff*	100% of Negotiated Tariff*
1.04. In-Hospital Radiology and Pathology. All Advanced/Specialised Radiology (such as CT, PET, MUGA and MRI scans), as well as Radio-isotope studies; require special authorisation and specialist referral. Failure to preauthorise would result in non-payment of claims.				
1.04.1. Basic Radiology and Pathology in-hospital	100% of Scheme Tariff	100% of Scheme Tariff Subject to Pre- authorisation, Hospital Benefit Management Programme, Disease Management Programme and PMB protocols.	100% of Scheme Tariff	100% of Scheme Tariff. Paid from Risk
1.04.2. Advanced Radiology: Joint benefit In and Out of Hospital Subject to pre-authorisation and specialist referral.	SPECIALISED RADIOLOGY: Limited to 2 scans per beneficiary per annum 10% co-payment is applicable for non-PMBs, MRI and CT scans	SPECIALISED RADIOLOGY: (MRI / CAT scan or angiogram) subject to an overall combined in and out of hospital limit of R34 434 per family per annum, pre-authorisation and managed care protocols.	SPECIALISED RADIOLOGY: Limited to 2 scans per beneficiary per annum 10% co-payment is applicable for non-PMBs, MRI and CT scans	SPECIALISED RADIOLOGY: (MRI / CAT scan or angiogram) Subject to an overall combined In and Out of hospital limit of R45 294 per family per annum.

IN HOSPITAL BENEFITS

	Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
1. Hospital, Hospital related Benefits, and Major Medical Expenses				
1.05. Major In-Hospital Medical Services and Procedures: All subject to pre-authorisation, treatment protocols and clinical guidelines. Prescribed Minimum Benefits applicable as prescribed. Failure to pre-authorise or to notify the scheme within 48 hours of an admission will result in non-payment of claims.				
1.05.1. Oncology Unlimited benefits for PMBs. Include consultations, investigations and treatment. Subject to the use of DSP and registration on the Disease Management Programme.	100 % of DSP Tariff* Standard oncology DSP* Protocols apply Limited to PMBs	100 % of DSP Tariff* Standard Oncology DSP* Protocols apply. Limited to PMBs	100% of DSP Tariff* Standard oncology DSP* Protocols apply Unlimited Oncology treatment Benefits in excess of R256 620 will be subject to 20% co-payment for non PMBs	Benefit is restricted to requirements set out in PMBs at a DSP.
1.05.2. Renal Dialysis: Unlimited benefits for PMBs. Include peritoneal and haemodialysis. Subject to pre- authorisation Department of Health Protocols apply. Unlimited benefits for PMBs. Include peritoneal and haemodialysis. Subject to pre-authorisation, clinical guidelines, medicine formulary*and registration on the Disease management programme.	100% of Negotiated Tariff* Limited to PMBs	100% of Negotiated Tariff* Limited to PMBs	100% of Negotiated Tariff*	100% Sizwe Hosmed rate
1.05.3. Organ Transplant: Unlimited benefits for PMBs. Subject to pre-authorisation, clinical guidelines and registration on the Disease Management Programme. Department of Health Protocols apply. Donor costs are not covered for beneficiaries donating to non-SIZWE HOSMED members	100% Scheme Tariff* Limited to PMBs	100% Scheme Tariff* Limited to R230 889 per family per year as specified.	100% Scheme Tariff*	General anaesthetic benefits are available for children under the age of seven (7) years for extensive dental treatment, limited to once per 365 days per beneficiary Removal of symptomatic impacted wisdom teeth, covered only as a Day case.

IN HOSPITAL BENEFITS

	Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
1. Hospital, Hospital related Benefits, and Major Medical Expenses				
1.05. Major In-Hospital Medical Services and Procedures: All subject to pre-authorisation, treatment protocols and clinical guidelines. Prescribed Minimum Benefits applicable as prescribed. Failure to pre-authorise or to notify the scheme within 48 hours of an admission will result in non-payment of claims.				
1.05.1. Oncology Unlimited benefits for PMBs. Include consultations, investigations and treatment. Subject to the use of DSP and registration on the Disease Management Programme.	100% of DSP Tariff* Enhanced oncology DSP* protocols apply Unlimited Oncology treatment. Benefits in excess of R546 000 per beneficiary, will be subject to 20% co-payment for non-PMBs	100% Sizwe Hosmed Rate Subject to pre- authorisation, managed care protocol and registration on the Hospital Benefit Management Programme Unlimited Oncology treatment. Benefits utilization in excess of R546 000 per beneficiary, will be subject to a 20% co-payment for non-PMBs	100% of DSP Tariff* Enhanced oncology DSP* protocols apply Unlimited Oncology treatment. Benefits in excess of R679 550 will be subject to 20% co-payment for non-PMBs	100% of DSP Tariff* Enhanced oncology DSP* protocols apply Unlimited Oncology treatment. Benefits utilisation in excess of R682 500 per beneficiary per annum will be subject to 20% co-payment for non-PMBs Non-Cancer Specialised Drugs Benefits (incl. Biologics) Subject to PMBs pre-authorisation, managed care and treatment guidelines. This benefit provides for non-cancer biological drugs.
1.05.2. Renal Dialysis: Unlimited benefits for PMBs. Include peritoneal and haemodialysis. Subject to pre- authorisation Department of Health Protocols apply. Unlimited benefits for PMBs. Include peritoneal and haemodialysis. Subject to pre-authorisation, clinical guidelines, medicine formulary*and registration on the Disease management programme.	100% of Negotiated Tariff*	Benefit is restricted to requirements set out in PMBs at a Preferred Provider.	100% of Negotiated Tariff*	100% of Negotiated Tariff*
1.05.3. Organ Transplant: Unlimited benefits for PMBs. Subject to pre-authorisation, clinical guidelines and registration on the Disease Management Programme. Department of Health Protocols apply. Donor costs are not covered for beneficiaries donating to non-SIZWE HOSMED members	100% of Scheme Tariff*	100% of Negotiated Tariff	100% of Scheme Tariff*	100% of Negotiated Tariff*

IN HOSPITAL BENEFITS

	Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
1. Hospital, Hospital related Benefits, and Major Medical Expenses				
1.05. Major In-Hospital Medical Services and Procedures: All subject to pre-authorisation, treatment protocols and clinical guidelines. Prescribed Minimum Benefits applicable as prescribed. Failure to pre-authorise or to notify the scheme within 48 hours of an admission will result in non-payment of claims.				
1.05.4. Dental Hospitalisation Subject to pre-authorisation, and treatment protocols	100% of Scheme Tariff* Limited to PMBs General anaesthetic benefits are available for children under the age of seven (7) years for extensive dental treatment, limited to once per 365 days per beneficiary Removal of symptomatic impacted wisdom teeth covered only as Day Case	100% of Scheme Tariff* Limited to PMBs General anaesthetic benefits are available for children under the age of seven (7) years for extensive dental treatment, limited to once per 365 days per beneficiary Removal of symptomatic impacted wisdom teeth covered only as Day Case in a Day Clinic.	100% of Scheme Tariff* General anaesthetic benefits are available for children under the age of seven (7) years for extensive dental treatment, limited to once per 365 days per beneficiary. Removal of symptomatic impacted wisdom teeth covered only as Day Case	100% of the Sizwe Hosmed rate, subject to managed care protocols Benefit for Temporo-Mandibular Joint (TMJ) therapy is limited to non-surgical intervention/ treatments
1.05.5. Maxillo-facial and Oral Surgery Subject to PMBs, pre-authorisation and treatment protocols	No benefit except for PMBs	100% negotiated Tariff* Limited to PMBs	No benefit except for PMBs	Subject to pre- authorisation, Treatment Protocols and PMBs 3 days withdrawal treatment plus 21 days Rehabilitation at an appropriate facility on pre-authorisation
1.05.6. Drug & Alcohol Rehabilitation Subject to PMBs, managed care protocols and pre-authorisation. Benefit limits apply	100% of Scheme Tariff* Limited to PMBs Limited to R13 498 per family per annum	100% of Scheme Tariff* Three (3) days withdrawal treatment, plus twenty one (21) days Rehabilitation.	100% of Scheme Tariff* Limited to R13 498 per family per annum	Subject to pre- authorisation, Treatment Protocols and PMBs 3 days withdrawal treatment plus 21 days Rehabilitation at an appropriate facility on pre-authorisation
1.05.7. Psychiatric Treatment Subject to PMBs, pre-authorisation and managed care protocols Includes consultations, ward fees, medicines, and psychiatry/psychology therapy sessions. **Non-PMB psychiatric treatment:** Admissions are limited to psychiatric emergencies and failed out-patient management as per Managed Care Protocols	100% of Scheme Tariff* 21 in-patient days per beneficiary or up to 15 out-patient contacts per annum No benefit	100% of Scheme Tariff* 21 in-patient days per beneficiary per annum. Includes six (6) in-hospital psychiatry consultations. Four (4) additional out of hospital consultations will be covered in lieu of hospitalisation No benefit	100% of Scheme Tariff* 21 in-patient days per beneficiary or up to 15 out-patient contacts per annum No benefit	Limited to 21 days per beneficiary per annum. This benefit includes psychiatrist consultations and six (6) in-hospital consultations by a clinical psychologist – subject to PMBs. Limited to R1 785 per day to a maximum value of R37 485 Four (4) additional out- of-hospital visits / consultations in lieu of hospitalisation are allowed subject to managed care protocols

IN HOSPITAL BENEFITS

	Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
1. Hospital, Hospital related Benefits, and Major Medical Expenses				
1.05. Major In-Hospital Medical Services and Procedures: All subject to pre-authorisation, treatment protocols and clinical guidelines. Prescribed Minimum Benefits applicable as prescribed. Failure to pre-authorise or to notify the scheme within 48 hours of an admission will result in non-payment of claims.				
1.05.4. Dental Hospitalisation Subject to pre-authorisation, and treatment protocols	100% of Scheme Tariff* General anaesthetic benefits are available for children under the age of seven (7) years for extensive dental treatment, limited to once per 365 days per beneficiary Removal of symptomatic impacted wisdom teeth covered only as Day Case	General anaesthetic benefits are available for children under the age of seven (7) years for extensive dental treatment, limited to once per 365 days per beneficiary. Removal of symptomatic impacted wisdom teeth, covered only as a Day case at a Day Hospital.	100% of Scheme Tariff* General anaesthetic benefits are available for children under the age of seven (7) years for extensive dental treatment, limited to once per 365 days per beneficiary Removal of symptomatic impacted wisdom covered only as Day Case	100% of Negotiated Tariff* General anaesthetic benefits are available for children under the age of seven (7) years for extensive dental treatment, limited to once per 365 days per beneficiary Removal of symptomatic impacted wisdom covered only as Day Case Removal of symptomatic impacted wisdom teeth, covered ONLY as a Day case at a day hospital.
1.05.5. Maxillo-facial and Oral Surgery Subject to PMBs, pre-authorisation and treatment protocols	100% of Scheme Tariff* Limited to symptomatic wisdom teeth and surgical exposure. All other procedures subject to PMB only. Removal of symptomatic impacted wisdom teeth only as a Day Case	100% of the Sizwe Hosmed rate, subject to managed care protocols Benefit for Temporo-Mandibular Joint (TMJ) therapy is limited to non-surgical intervention/ treatments	100% of Scheme Tariff* Limited to symptomatic wisdom teeth and surgical exposure. All other procedures subject to PMB only Removal of symptomatic impacted wisdom teeth only as a Day Case	100% of Scheme Tariff* Benefit for Temporo-Mandibular Joint (TMJ) therapy is limited to non-surgical intervention/ treatments. The claims for oral pathology procedures (cysts and biopsies, the surgical treatment of tumours of the jaw and soft tissue tumours) will only be covered if supported by a laboratory report that confirms diagnosis
1.05.6. Drug & Alcohol Rehabilitation Subject to PMBs, managed care protocols and pre-authorisation. Benefit limits apply	100% of Scheme Tariff* Limited to R21 131 per family per annum	Subject to pre- authorisation, Treatment Protocols and PMBs 3 days withdrawal treatment plus 21 days Rehabilitation at an appropriate facility on Pre-authorisation	100% of Scheme Tariff* Limited to R21 457 per family per annum	100% of Scheme Tariff* Only 3 days withdrawal treatment and up to 21 days admission for rehabilitation at an appropriate facility.
1.05.7. Psychiatric Treatment Subject to PMBs, pre-authorisation and managed care protocols Includes consultations, ward fees, medicines, and psychiatry/psychology therapy sessions. Non-PMB psychiatric treatment: Admissions are limited to psychiatric emergencies and failed out-patient management as per Managed Care Protocols	100% of Scheme Tariff* 21 in-patient days per beneficiary or up to 15 out-patient contacts per annum 14 days per family subject to a limit of R R22 397 Up to 3 days for Psychologist for combined therapy sessions with Psychiatrist during the same admission; thereafter pre-authorisation required with treatment plan.	Limited to 21 days per beneficiary per year. This benefit includes psychiatrist consultations and six (6) in hospital consultations by clinical psychologist – subject to PMBs. Limited to R2 100 per day to a maximum value of R44 100 Four (4) additional out of hospitals consultations in lieu of hospitalisation are allowed subject to managed care protocols	100% of Scheme Tariff* 21 in-patient days per beneficiary or up to 15 out-patient contacts per annum 14 days per family subject to a limit of R25 195 Up to 3 days for psychologist for combined therapy sessions with Psychiatrist during the same admission; thereafter pre-authorisation required with treatment plan.	100% of Negotiated Tariff* 21 in-patient days per beneficiary per annum. Includes psychiatrist consultations and 6 in-hospital consultations by clinical psychologist Subject to available benefits of R50 715 per member per admission at R2 415 per day. Four (4) additional out of hospitals visits/ consultations in lieu of hospitalisation are allowed subject to managed care protocols

IN HOSPITAL BENEFITS

	Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
1. Hospital, Hospital related Benefits, and Major Medical Expenses				
1.05. Major In-Hospital Medical Services and Procedures: All subject to pre-authorisation, treatment protocols and clinical guidelines. Prescribed Minimum Benefits applicable as prescribed. Failure to pre-authorise or to notify the scheme within 48 hours of an admission will result in non-payment of claims.				
1.05.8. Step down facility including Rehabilitation Facilities Subject to PMBs, pre-authorisation and protocols.	100% of Negotiated Tariff* Limited to PMBs	100% of Negotiated Tariff*	100% of Negotiated Tariff* Limited to 14 days per beneficiary per annum	Management Programme and the Disease Management Programme. 100% Sizwe Hosmed rates for all services rendered at registered step-down facilities, nursing facilities. Hospice at 100% of cost. 100% Sizwe Hosmed rates for services rendered under Home Care in lieu of Hospitalisation
1.05.9. Home Based Care In lieu of hospitalisation Subject to PMBs, pre-authorisation and protocols.	100% of Negotiated Tariff* Limited to 14 days per annum PMBs only	100% of Negotiated Tariff* Limited to 14 days per annum	100% of Negotiated Tariff* Limited to 14 days per beneficiary per annum	Subject to benefits at Sizwe Hosmed Private Nurse rates and Pre-Authorisation. Limit per year per family – R5 505 Frail care is not a covered benefit. PMB applicable
1.05.10. Negative pressure wound therapy Subject to PMBs, pre-authorisation and protocols.	100% of Negotiated Tariff* Limited to PMB conditions only	100% of Negotiated Tariff*	100% of Negotiated Tariff* Subject to PMB conditions only	
1.05.11. Hyperbaric Oxygen Therapy Subject to PMBs, pre-authorisation and protocols.	100% of Negotiated Tariff* Limited to PMBs Public sector protocols apply	100% of Negotiated Tariff* Public sector protocols apply	100% of Negotiated Tariff* Limited to PMBs Public sector protocols apply	100% of Negotiated Tariff* Limited to PMBs Public sector protocols apply
1.05.12. Male Sterilisation/ Vasectomy Subject to pre-authorisation and PMBs	100% of Negotiated Tariff* Limited to PMBs	100% of Negotiated Tariff*	100% of Negotiated Tariff* Sterilisation limited to R17 472 per beneficiary per annum	100% of Negotiated Tariff* Sterilisation limited to r annum
1.0.5.13. Female Sterilisation/ Tubal Ligation Subject to pre-authorisation at Day Clinic or as Day Case, and subject to PMBs.	100% of Negotiated Tariff* Limited to PMBs	100% of Negotiated Tariff*	100% of Negotiated Tariff* Sterilisation limited to R17 472 per beneficiary per annum	100% of Negotiated Tariff* Sterilisation limited to R17 472 per beneficiary per annum
1.05.14. Back and Neck Surgery Subject to PMBs, pre-authorisation and adherence of the conservative back and neck treatment protocol	100% of Scheme Tariff* Limited to PMBs	100% of Scheme Tariff* Authorisation for spinal surgery for the treatment of chronic back and/or neck pain are subject to managed care protocols. Managed care may request adherence to conservative clinical treatment prior to authorising surgery	100% of Scheme Tariff* Limited to PMBs. Authorisation for spinal surgery for the treatment of chronic back and/or neck pain are subject to managed care protocols Managed care may request adherence to conservative clinical treatment prior to authorising surgery	Authorisation for spinal surgery for the treatment of chronic back and/or neck pain are subject to managed care protocols. Managed care may request adherence to conservative clinical treatment prior to authorising surgery

IN HOSPITAL BENEFITS

	Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
1. Hospital, Hospital related Benefits, and Major Medical Expenses				
1.05. Major In-Hospital Medical Services and Procedures: All subject to pre-authorisation, treatment protocols and clinical guidelines. Prescribed Minimum Benefits applicable as prescribed. Failure to pre-authorise or to notify the scheme within 48 hours of an admission will result in non-payment of claims.				
1.05.8. Step down facility including Rehabilitation Facilities Subject to PMBs, pre-authorisation and protocols.	100% of Negotiated Tariff* Limited to 14 days per beneficiary per annum	Subject to the Hospital Benefit Management Programme and the Disease Management Programme. 100% Sizwe Hosmed rates for all services rendered at registered step-down facilities, nursing facilities. Hospice at 100% of cost. 100% Sizwe Hosmed rates for services rendered under Home Care in lieu of Hospitalisation	100% of Negotiated Tariff* Limited to 14 days per beneficiary per annum	100% of Negotiated Tariff*
1.05.9. Home Based Care In lieu of hospitalisation Subject to PMBs, pre-authorisation and protocols.	100% of Negotiated Tariff* Limited to 14 days per beneficiary per annum	Subject to benefits at Sizwe Hosmed Private Nurse rates and Pre-Authorisation. Limit per year per family – R5 505 Frail care is not a covered benefit.	100% of Negotiated Tariff* Limited to 14 days per beneficiary per annum	100% of Negotiated Tariff*. Paid from Risk Limit per year per family: R11 010
1.05.10. Negative pressure wound therapy Subject to PMBs, pre-authorisation and protocols.	100% of Negotiated Tariff* Limited to R29 274 per family per annum		100% of Negotiated Tariff* Limited to R29 657 per family per annum	100% of Negotiated Tariff*
1.05.11. Hyperbaric Oxygen Therapy Subject to PMBs, pre-authorisation and protocols.	100% of Negotiated Tariff* Limited to R46 452 per family per annum	100% of Negotiated Tariff* Limited to PMBs Public sector protocols apply	100% of Negotiated Tariff* Limited to R53 965 per family per annum	100% of Negotiated Tariff*
1.05.12. Male Sterilisation/ Vasectomy Subject to pre-authorisation and PMBs	100% of Scheme Tariff* Sterilisation limited to R17 472 per beneficiary per annum	100% of Negotiated Tariff* Sterilisation limited to R17 472 per beneficiary per annum	100% of Scheme Tariff* Limited to R17 472 per beneficiary per annum	100% of Scheme Tariff*
1.0.5.13. Female Sterilisation/ Tubal Ligation Subject to pre-authorisation at Day Clinic or as Day Case, and subject to PMBs.	100% of Scheme Tariff* Sterilisation limited to R17 472 per beneficiary per annum	100% of Negotiated Tariff* Sterilisation limited to R17 472 per beneficiary per annum	100% of Scheme Tariff* Sterilisation limited to R17 472 per beneficiary per annum	100% of Scheme Tariff*
1.05.14. Back and Neck Surgery Subject to PMBs, pre-authorisation and adherence of the conservative back and neck treatment protocol	100% of Scheme Tariff* Authorisation for spinal surgery for the treatment of back and neck pain are subject to managed care protocols. Managed Care may request adherence to conservative treatment prior to authorising surgery	Authorisation for spinal surgery for the treatment of chronic back and/or neck pain are subject to managed care protocols. Managed care may request adherence to conservative clinical treatment prior to authorising surgery	100% of Scheme Tariff* Authorisation for spinal surgery for the treatment of chronic back and/or neck pain are subject to managed care protocols. Managed care may request adherence to conservative clinical treatment prior to authorising surgery	Authorisation for spinal surgery for the treatment of chronic back and neck pain are subject to managed care protocols. Managed Care may request adherence to conservative treatment prior to authorising surgery.

IN HOSPITAL BENEFITS

	Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
1. Hospital, Hospital related Benefits, and Major Medical Expenses				
1.05. Major In-Hospital Medical Services and Procedures: All subject to pre-authorisation, treatment protocols and clinical guidelines. Prescribed Minimum Benefits applicable as prescribed. Failure to pre-authorise or to notify the scheme within 48 hours of an admission will result in non-payment of claims.				
1.05.15. Stereotactic Radio-Surgery Subject to PMBs, pre-authorisation and protocols.	No benefit, except for PMBs	100% of Scheme Tariff*	No benefit, except for PMBs	100% of Scheme Tariff* Primary Central Nervous System tumours only
1.05.16. Age Related Muscular Degeneration Treatment Subject to PMBs, pre-authorisation and Scheme formulary* and protocol	100% Negotiated Tariff Limited to PMBs	100% of Scheme Tariff*	100% of Negotiated Tariff	100% of Negotiated Tariff
1.05.17. Laparoscopic Hospitalisation and Associated Costs Subject to PMBs, pre-authorisation and protocols. No co-payment applicable when procedure performed in a Day Hospital or as a Day Case **Non-PMB laparoscopic procedures will be considered for funding up to PMB level of care for patients who meet the clinical criteria subject to Pre-authorisation and protocols.**	100% of Scheme Tariff* No co-payment applicable when laparoscopic procedures are performed at Day Hospitals or as a Day Case. Procedures done in-hospital will attract a R5 250 co-payment* with exception of diagnostic laparoscopy, Aspiration/excision ovarian cyst, Lap-appendicectomy and repair of recurrent or bilateral inguinal hernias	100% of Scheme Tariff* No co-payment applicable when laparoscopic procedures are performed at Day Hospitals or as a Day Case. Procedures done in-hospital instead of Day Clinic will attract a R5 250 co-payment* with exception of diagnostic laparoscopy, Aspiration/ excision ovarian cyst, Lap-appendicectomy and repair of recurrent or bilateral inguinal hernias	100% of Scheme Tariff* No co-payment applicable when laparoscopic procedures are performed at Day Hospitals or as a Day Case. Procedures done in-hospital will attract a R5 250 co-payment* with exception of diagnostic laparoscopy, Aspiration/excision ovarian cyst, Lap-appendicectomy and repair of recurrent or bilateral inguinal hernias	Covered in terms of PMBs at DSP facilities, subject to clinical protocol

IN HOSPITAL BENEFITS

	Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
1. Hospital, Hospital related Benefits, and Major Medical Expenses				
1.05. Major In-Hospital Medical Services and Procedures: All subject to pre-authorisation, treatment protocols and clinical guidelines. Prescribed Minimum Benefits applicable as prescribed. Failure to pre-authorise or to notify the scheme within 48 hours of an admission will result in non-payment of claims.				
1.05.15. Stereotactic Radio-Surgery Subject to PMBs, pre-authorisation and protocols.	100% of Scheme Tariff* Primary Central Nervous System tumours only	100% of Negotiated Tariff* Primary Central Nervous System tumours only	100% of Scheme Tariff* Primary Central Nervous System tumours only	100% of Scheme Tariff*
1.05.16. Age Related Muscular Degeneration Treatment Subject to PMBs, pre-authorisation and Scheme formulary* and protocol	100% of Negotiated Tariff	100% of Negotiated Tariff	100% of Negotiated Tariff	100% of Negotiated Tariff
1.05.17. Laparoscopic Hospitalisation and Associated Costs Subject to PMBs, pre-authorisation and protocols. No co-payment applicable when procedure performed in a Day Hospital or as a Day Case Non -PMB laparoscopic procedures will be considered for funding up to PMB level of care for patients who meet the clinical criteria subject to Pre-authorisation and protocols.	100% of Scheme Tariff* No co-payment applicable when laparoscopic procedures are performed at Day Hospitals or as a Day Cases. Procedures done in-hospital will attract a R5 250 co-payment* with exception of diagnostic laparoscopy, Aspiration/excision ovarian cyst, Lap-appendicectomy and repair of recurrent or bilateral inguinal hernias	Covered in terms of PMBs at DSP facilities, subject to clinical protocol	100% of Scheme Tariff* No co-payment applicable when laparoscopic procedures are performed at Day Hospitals or as a Day Case. Procedures done in-hospital will attract a R5 250 co-payment* with exception of diagnostic laparoscopy, Aspiration/excision ovarian cyst, Lap-appendicectomy and repair of recurrent or bilateral inguinal hernias	100% of Scheme Tariff*

IN HOSPITAL BENEFITS

	Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
1. Hospital, Hospital related Benefits, and Major Medical Expenses (continued)				
1.06. Other In-Hospital Medical Services: All benefits subject to PMBs, pre-authorisation, clinical protocols, medical management and benefit availability.				
1.06.1. Internal and External Prosthesis Subject to PMBs, and pre-authorisation	100% of Negotiated Tariff* Overall prosthesis limit: R21 457per family per annum Limited to PMBs	100% of Negotiated Tariff* Limited to PMBs	100% of Negotiated Tariff* Overall prosthesis limit: R33 731, per family per annum. Limited t to PMBs	100% of Negotiated Tariff
Instrumentation and disc prostheses including all components and fixation devices for back/spine Maximum 1 event per beneficiary per annum	Limited to PMBs		Limited to PMBs	Surgical and non- surgical prosthesis subject to annual limit of R31 043 per family within hospital limit.
Internal Prosthesis:	Prosthesis limited to equivalent available in the state. Excludes cement		Subject to overall limit Excludes cement.	Subject to benefit limit unless PMB. Pacemakers; Defibrillators; Spinal fusion – only one spine level per beneficiary; Should more than one (1) spinal level be required, approval will be granted subject to managed care protocols. Grafts; Joints – hip and knee (partial and total) - only one joint per beneficiary per annum; Other clinically appropriate unspecified prosthetic items
External Prosthesis:	Limited to PMBs		Limited to PMBs	
Aphakic Lenses (Subject to protocol and PMBs)	Limited to PMBs		R5 628 per lens	
Cardiac stents Subject to overall prosthesis limit and PMB protocols	Limited to PMBs 1 per lesion- maximum of 3 lesions. Public sector protocols for STEMI apply. No benefit for unstable angina or NSTEMI unless there is evidence of failed conservative medical treatment.		Limited to PMBs. 1 per lesion- maximum of 3 lesions. Public sector protocols for STEMI apply. No benefit for unstable angina or NSTEMI unless there is evidence of failed conservative medical treatment.	Subject to benefit limit unless PMB Artificial limb; Breast, Ocular; Taylor Spatial frame; External fixator; Mesh;, Other clinically appropriate unspecified prosthetic items.
Internal sphincters and stimulators	Subject to overall prosthesis benefit Limited to PMBs		Subject to overall prosthesis benefit Limited to PMBs	Cardiac stents – 3 unless PMB; Vascular stents - 2 stents per family per annum
Neurostimulators/ Internal nerve stimulator for Parkinson's Disease	No benefit		No benefit	
Cochlear implants	No benefit		No benefit	
Insulin pumps and monthly materials	No benefit		No benefit	
Unlisted prosthesis Artificial Limbs and external prostheses including artificial eyes	Maximum R10 190 subject to overall prosthesis limit		Maximum R12 731 subject to overall prosthesis limit	
1.06.2. Blood Transfusions	100% of Scheme Tariff* Limited to PMBs	100% of Scheme Tariff*	100% of Scheme Tariff* Limited to PMBs	100% of Scheme Tariff*
1.06.3. Physiotherapy & Biokinetics Subject to PMBs, treating doctor referral and pre-authorisation by the auxiliary service provider during the admission period Subject to Scheme protocols	100% of Scheme Tariff* Limited to PMBs	100% of Scheme Tariff*	100% of Scheme Tariff* Limited to PMBs	100% of Scheme Tariff*

IN HOSPITAL BENEFITS

Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
1. Hospital, Hospital related Benefits, and Major Medical Expenses (continued)			
1.06. Other In-Hospital Medical Services: All benefits subject to PMBs, pre-authorisation, clinical protocols, medical management and benefit availability.			
1.06.1. Internal and External Prosthesis Subject to PMBs, and pre-authorisation Instrumentation and disc prostheses including all components and fixation devices for back/spine Maximum 1 event per beneficiary per annum Internal Prosthesis: External Prosthesis: Aphakic Lenses (Subject to protocol and PMBs) Cardiac stents Subject to overall prosthesis limit and PMB protocols Internal sphincters and stimulators Neurostimulators/ Internal nerve stimulator for Parkinson's Disease Cochlear implants Insulin pumps and monthly materials Unlisted prosthesis Artificial Limbs and external prostheses including artificial eyes	100% of Negotiated Tariff* Overall prosthesis limit: R52 406 per family per annum Sub limits: R25 499 per level, subject to overall limit. Limited to a maximum of 2 levels unless clinically motivated and approved or within PMB protocols. R46 321 per annum. Subject to the overall limit. Limited to one event per annum unless sepsis or trauma. Excludes cement R6 452 per lens 1 per lesion, maximum 3 lesions. Subject to overall prosthesis limit Bare metal stents: R16 774 per stent Drug eluting stents: R23 625 per stent Subject to overall prosthesis limits Limited to PMBs Subject to overall prosthesis limits No benefit Maximum R15 278 Subject to overall limit	Surgical and non- surgical prosthesis subject to an annual limit of R51 743 per family within hospital limit . Joints – hip and knee (partial and total), only one prosthesis and only one joint per annum. Spine – two (2) levels per year done in one procedure. Cardiac (Pacemaker, internal defibrillators, grafts, valves) subject to benefits and PMB. Vascular stents – two stents per family per annum . Cardiac stents – three stents per family per annum. External Prosthesis Subject to benefit limit. PMB protocols apply	100% of Negotiated Tariff* Overall prosthesis limit: R75 348 per family per annum Sub-Limits: R31 832 per level, subject to overall benefit limit Limited to a maximum of 2 levels unless clinically motivated and approved or within PMB protocols. R46 321 per annum, subject to overall benefit limit. Limited to one event per annum unless sepsis or trauma. Excludes cement R6 452 per lens per annum 1 per lesion-maximum 3 lesions Bare metal stents: R16 774 per stent Drug eluting stents: R23 625 per stent Limited to PMBs Subject to overall prosthesis limit Subject to overall prosthesis limit Subject to overall prosthesis limit. Children under 7 years of age only. Maximum R19 089 Subject to overall limit	100% Negotiated Tariff* Surgical & Non-Surgical: 100% of the cost of prosthesis subject to an annual limit of R68 305 per family within hospital limit as stipulated Joints – hip and knee (partial internal Prosthesis and total) Only one prosthesis and only one joint per beneficiary per cycle Spine –two (2) levels per year done in one procedure Cardiac - Pacemaker, internal defibrillators, grafts, valves Vascular stents – two stents per family per annum Cardiac stents – three stents per family per annum
1.06.2. Blood Transfusions	100% of Scheme Tariff*	100% of Scheme Tariff*	100% of Scheme Tariff*	100% of Scheme Tariff*
1.06.3. Physiotherapy & Biokinetics Subject to PMBs, treating doctor referral and pre-authorisation by the auxiliary service provider during the admission period Subject to Scheme protocols	100% of Scheme Tariff*	100% of Scheme Tariff*	100% of Scheme Tariff*	100% of Scheme Tariff*

IN HOSPITAL BENEFITS

	Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
1. Hospital, Hospital related Benefits, and Major Medical Expenses (continued)				
1.06. Other In-Hospital Medical Services: All benefits subject to PMBs, pre-authorisation, clinical protocols, medical management and benefit availability.				
1.06.2. Blood Transfusions	100% of Scheme Tariff* Limited to PMBs	100% of Scheme Tariff*	100% of Scheme Tariff* Limited to PMBs	100% of Scheme Tariff*
1.06.3. Physiotherapy & Biokinetics Subject to PMBs, treating doctor referral and pre-authorisation by the auxiliary service provider during the admission period Subject to Scheme protocols	100% of Scheme Tariff* Limited to PMBs	100% of Scheme Tariff*	100% of Scheme Tariff* Limited to PMBs	100% of Scheme Tariff*
1.06.4. Dietician & Occupational Therapy Subject to PMBs, treating doctor referral and pre-authorisation by the auxiliary service provider during the admission period Subject to Scheme protocols	100% of Scheme Tariff* Limited to PMBs	100% of Scheme Tariff*	100% of Scheme Tariff* Limited to PMBs	100% of Scheme Tariff*
1.06.4. Deductible* Applied for In-Hospital Procedures	Not applicable	100% Scheme tariff Limited to PMB	• Skin disorders • Arthroscopy • Bunionectomy • Removal of varicose veins • Refractive eye surgery, Aphakic lenses • Infertility treatment • Non-cancerous breast conditions	Not applicable

IN HOSPITAL BENEFITS

	Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
1. Hospital, Hospital related Benefits, and Major Medical Expenses (continued)				
1.06. Other In-Hospital Medical Services: All benefits subject to PMBs, pre-authorisation, clinical protocols, medical management and benefit availability.				
1.06.2. Blood Transfusions	100% of Scheme Tariff*	100% of Scheme Tariff*	100% of Scheme Tariff*	100% of Scheme Tariff*
1.06.3. Physiotherapy & Biokinetics Subject to PMBs, treating doctor referral and pre-authorisation by the auxiliary service provider during the admission period Subject to Scheme protocols	100% of Scheme Tariff*	100% of Scheme Tariff*	100% of Scheme Tariff*	100% of Scheme Tariff*
1.06.4. Dietician & Occupational Therapy Subject to PMBs, treating doctor referral and pre-authorisation by the auxiliary service provider during the admission period Subject to Scheme protocols	100% of Scheme Tariff*	100% of Scheme Tariff*	100% of Scheme Tariff*	100% of Scheme Tariff*
1.06.4. Deductible* Applied for In-Hospital Procedures	• Joint Replacement • Umbilical Hernia Repair • Hysterectomy • Functional Nasal Surgery • Elective caesarean section	Not applicable	Not applicable	Not applicable

DAY-TO-DAY BENEFITS

	Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
2. Day-to-Day Procedures				
2.1. Day Hospital Procedures **Procedures to be done at Designated Service Provider (DSP*) hospital network** **Subject to pre-authorisation** **Co-payment* still applicable to defined conditions herein.**	Subject to Scheme Tariff* Subject to PMB conditions only: 1. Biopsy 2. Breast Biopsy 3. Cataract 4. Colonoscopy 5. Cone Biopsy/ Colposcopy 6. Cystoscopy 7. ERCP 8. Excision of Extensive Skin lesions /Repair/Skin Graft 9. Gastroscopy or Colonoscopy or Oesophagoscope 10. Haemorrhoidectomy 11. Hysteroscopy, D&C, Minor Gynaecological Procedures 12. Myringotomy / Grommets 13. Repair of Wounds 14. Termination of Pregnancy 15. Tonsillectomy and Adenoidectomy 16. Umbilical and Inguinal Hernia	100%Negotiated Tariff* Co-Payment applicable to defined conditions below. Limited to PMB conditions only: Subject to PMB conditions only: 1. Umbilical and Inguinal hernia repair 2. Colonoscopy 3. Cystoscopy Gastroscopy and Oesophagoscopy 4. Hysteroscopy 5. Grommets 6. Termination of pregnancy 7. Breast biopsy 8. Cataracts 9. Circumcision 10. ERCP 11. Haemorrhoidectomy 12. Vasectomy 13. Tubal Ligation 14. Excision of extensive skin lesions or repair of wounds and skin grafts 15. Dental procedures 16. Repair nail bed & Removal of toenails 17. Minor orthopaedic procedures such as tennis elbow, dupuytren's contracture, trigger finger, ganglion, carpal tunnel syndrome 18. Minor Gynaecological procedures – cone biopsy, colposcopy, D& 19. Mirena device for abnormal uterine bleeding	R1 662, Deductible* – Except for PMB's • Colonoscopy • Facet joint injections • Myringotomy R3 323 Deductible* – Except for PMB's • Gastroscopy • Cystoscopy • Hysteroscopy • Flexible • sigmoidoscopy • Percutaneous radiofrequency ablations • Percutaneous rhizotomies R5 539 Deductible* – Except for PMB's • Elective caesarean delivery • Joint replacements • Back surgery, including spinal fusion • Umbilical hernia repair • Hysterectomy • Functional nasal surgery	100% of Scheme Tariff*

DAY-TO-DAY BENEFITS

2. Day-to-Day Procedures	Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
2.1. Day Hospital Procedures Procedures to be done at Designated Service Provider (DSP*) hospital network Subject to pre-authorisation Co-payment* still applicable to defined conditions herein.	100% of Scheme Tariff* General Practitioner Consultations: 20 GP Visits per family per annum. Limited to 10 GP visits per beneficiary A 30% co-payment will apply after the 7th GP visit per beneficiary. Specialist Consultations: Member: 3 Visits Member + 1 = 5 Visits Member + 2 + = 7 Visits	100% Scheme Tariff. Paid from available savings and/or above threshold benefit 100% of Scheme Tariff.	100% of Scheme Tariff* General Practitioner Consultations: 16 GP Visits per Beneficiary limited to 26 GP visits per Family per Annum. A 30% co-payment will apply after the 10th GP visit per beneficiary. Specialist Consultations: Member: 5 Visits Member + 1 = 7 Visits Member + 2 + = 9 Visits	100% of Scheme Tariff* Paid from available MSA and/ or above threshold benefit

DAY-TO-DAY BENEFITS

	Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
2.2. Consultations (Out-of-Hospital – Including General Practitioners, Specialist and Outpatient Facilities)	100% of DSP Tariff* General Practitioner Consultations: Obky DSP* GP subject to PMB Unlimited visits & acute medication from any GP within the DSP* Network at 100% of DSP* Tariff* A 30% co-payment will apply for GP consultations outside the DSP* Network. Specialist Consultations: 100% of Scheme Tariff* Limited to 3 visits per family per annum only on referral from DSP* GP. Subject to pre-authorisation Limited to PMB conditions only	100% Scheme Tariff* Limited to PMB	100% Scheme Tariff* General Practitioner Consultations: Paid from MSA* Consultations once MSA* depleted: 4 Additional GP Visits per Family limited to 1 per beneficiary once MSA* depleted. If the specialist consultation once MSA is depleted benefit is utilised, the additional GP visits are limited to 3 per family and 1 per beneficiary. Specialist Consultations: Paid from MSA* Consultations once MSA* depleted: 1 Additional specialist Visit per Family once MSA* is depleted with any one of the following specialists: • Paediatricians • Gynaecologists	**Day to Day Benefits** Member: R6 884 Member +1 : R10 194 Member +2 : R11 930 Member +3 : R13 643 Member +4 : R15 377 Member +5 : R17 101 Member +6+ : R18 814 General Practitioners – Visits Subject to Day-To-Day benefit One (1) extra visit per single member per annum is applicable for preventative care Member: 6 Member +1 : 9 Member +2 : 12 Member +3 : 14 Member +4 : 15 Member +5 : 16 Member +6+ : 17 Specialists (Excluding Psychiatrists) – Visits Subject to Day-To-Day benefit, referral to the specialist by a GP is mandatory, unless not possible as in the case of an unavailable GP, in an emergency, or a follow-up specialist visit after an initial GP referral. Failure to get the required GP referral will result in the Scheme paying an equivalent of the Scheme GP rate. Member: 2 Member +1 : 6 Member +2 : 7 Member +3 : 8 Member +4 : 9 Member +5 : 10 Member +6+ : 11
2.3. Acute Medicines	100% of Reference Price* DSP* GP Unlimited Acute medication dispensed by the DSP* GP Acute Medication Obtained from Pharmacy: R1 386 per beneficiary limited to R3 864 per family per annum Subject to Medicine formulary* and Protocols, Including Materials. Homeopathic Medication excluded	100% of Scheme Tariff* Limited to CDL	100% of Reference Price* Paid from MSA* Acute Medication Obtained from Pharmacy: Subject to funds available in MSA	Subject to Day-to-Day Member: R2 149 Member + 1: R3 873 Member + 2: R4 310 Member + 3: R4 885 Member + 4: R5 022 Member + 5: R5 298 Member + 6: R5 735

DAY-TO-DAY BENEFITS

	Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
2.2. Consultations (Out-of-Hospital – Including General Practitioners, Specialist and Outpatient Facilities)	100% of Scheme Tariff* General Practitioner Consultations: 20 GP Visits per family per annum. Limited to 10 GP visits per beneficiary A 30% co-payment will apply after the 7th GP visit per beneficiary. Specialist Consultations: Member: 3 Visits Member + 1 = 5 Visits Member + 2 + = 7 Visits	100% Scheme Tariff. Paid from available savings and/or above threshold benefit 100% of Scheme Tariff.	100% of Scheme Tariff* General Practitioner Consultations: 16 GP Visits per Beneficiary limited to 26 GP visits per Family per Annum. A 30% co-payment will apply after the 10th GP visit per beneficiary. Specialist Consultations: Member: 5 Visits Member + 1 = 7 Visits Member + 2 + = 9 Visits	100% of Scheme Tariff* Paid from available MSA and/or above threshold benefit
2.3. Acute Medicines	100% of Reference Price* R10 427 per family per annum Limited to R5 943 per beneficiary per annum 20% co-pay will apply for benefit utilisation above R6 379 per family Homeopathic Medicines: No benefit	100% Scheme Tariff*. Paid from MSA. No self payment gap or above threshold benefits.	100% of Reference Price* R16 763 per family per annum. Limited to R9 854 per beneficiary 20% co-pay will apply for benefit utilisation above R10 416 per family	100% of Reference Price* Paid from available MSA and/or above threshold benefit. The following limits apply for above threshold benefits: Main Member= R7 000 Adult Dependent= R7 000 Child= R2 000) 100% of Reference Price*

DAY-TO-DAY BENEFITS

	Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
2.4. PMB Chronic Disease List Medicines PMB's subject to registration and pre-authorisation with the Schemes preferred provider. Chronic Medication to be Obtained from Preferred Provider Network. Subject to renewal of prescription every six months.	100% of Reference Price* Unlimited Subject to pre-authorisation by Designated Service Provider, Treatment Protocols, Medicine formulary* and Registration of the Chronic Medicine by the DSP* GP. Provider Network Only		100% of Reference Price* Unlimited Paid from Risk Pool Subject to pre-authorisation, treatment protocols, Medicine formulary* and Registration of the Chronic Medicine by GP.	100% of Reference Price*. Unlimited The beneficiary is registered on the Chronic Disease Management Programme Medicines prescribed are within the formulary and where the formulary is not adhered to, a reference price will be applied
2.5. Other Chronic (Non CDL) Medicines PMB's subject to registration and pre-authorisation with the Schemes preferred provider. Chronic Medication to be Obtained from Preferred Provider Network. Subject to renewal of prescription every six months.	No benefit	No benefit	No benefit	100% of Scheme Tariff*
2.6. Pharmacy Advised Treatment (PAT) Over the Counter Medication Consultation with Pharmacist, restricted to Schedule 0, 1 and 2 medicines. PAT subject to acute benefit limit	100% of Reference Price* Limited to R709 per Family per annum Maximum R110 per script.		100% of Reference Price* Paid from MSA*	Subject to acute medication and Day to Day limit
2.7. Contraceptive benefit 2.7.1. Mirena Device	100% of Reference Price* Limited to R79 per beneficiary per month, subject to R840 per family per annum. Subject to oral and injectable contraceptives only Subject to the contraceptive formulary*		100% of Reference Price* Paid from MSA* Subject to the contraceptive formulary* Subject to a sub-limit of R2 100 per beneficiary every 5 years for abnormal uterine bleeding paid from MSA.	Limit of R3 172 per family per annum subject to Managed Care Protocols and formulary Mirena device: No benefit

DAY-TO-DAY BENEFITS

	Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
2.4. PMB Chronic Disease List Medicines Subject to registration on the Chronic Medicine programme, and pre-authorisation with the Schemes Pharmacy Benefit Manager. Subject to, clinical protocol, medicine formulary*, and the use of Pharmacy Preferred Provider Pharmacy Networks. Subject to renewal of prescription every six months.	100% of Reference Price* Unlimited benefit Non-formulary* products will incur a 30% co-payment* when obtained voluntarily* by beneficiaries.	100% of Reference Price*. Unlimited The beneficiary is registered on the Chronic Disease Management Programme Medicines prescribed are within the formulary and where the formulary is not adhered to, a reference price will be applied	100% of Reference Price* Unlimited benefits Non-formulary* products will incur a 30% co-payment* when obtained voluntarily by beneficiaries. Benefit Initially payable from limit other chronic benefit limit.	100% of Reference Price* Unlimited. Paid from Risk
2.5. Other Chronic (Non CDL) Medicines PMB's subject to registration and pre-authorisation with the Schemes preferred provider. Chronic Medication to be Obtained from Preferred Provider Network. Subject to renewal of prescription every six months.	100% of Reference Price* R15 246 per family per annum Limited to R7 560 per beneficiary per annum Non-formulary* products will incur a 30% co-payment* where these are obtained voluntarily by beneficiaries.	R15 246 per family per annum Limited to R7 560 per beneficiary per annum. Paid from Risk	100% of Reference Price* R16 044 per beneficiary Limited to R30 676 per family per annum Subject to pre-authorisation, treatment protocols and medicine formulary* Non-formulary* products will incur a 30% co-payment* where these are obtained voluntarily by beneficiaries.	100% of Reference Price* Paid from Risk R16 044 per beneficiary Limited to R30 676 per family per annum Non-formulary* products will incur a 30% co-payment* where these are obtained voluntarily by beneficiaries.
2.6. Pharmacy Advised Treatment (PAT) Over the Counter Medication Consultation with Pharmacist, restricted to Schedule 0, 1 and 2 medicines. PAT subject to acute benefit limit	100% of Reference Price* Limited to R2 216 per family per annum Maximum R173 per script Included in Limit 3.1 above	100% Scheme Tariff*. Paid from MSA. No self payment gap or above threshold benefits.	100% of Reference Price* R3 507 per family per annum Maximum R252 per script Included in Limit 3.1 above	100% of Reference Price* Paid from available MSA and/ or above threshold benefit
2.7. Contraceptive benefit 2.7.1. Mirena Device	100% of Reference Price* Limited to R1 528 per family per annum. Subject to oral, injectable and patch contraceptives only Subject to a sub-limit of R2 100 per beneficiary every 5 years for abnormal uterine bleeding.	Limit of R3 172 per family per annum. Paid from available savings and/or above threshold benefit No benefit	100% of Reference Price* Limited to R1 838 per family per annum. Subject to oral, injectable and patch contraceptives only Subject to the contraceptive formulary* Subject to a sub-limit of R2 100 per beneficiary every 5 years for abnormal uterine bleeding	Contraceptives benefit Subject to Managed Care Protocols and formulary Limit of R3 172 per family per annum. Paid from available MSA and/or above threshold benefit

OPTICAL BENEFITS

	Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
3. Optical Benefits **Benefit applicable to members who utilize the Scheme's DSP network optometrist only, Paid from Risk**				
3.1. Spectacle Lenses: In Network ONLY Benefit applicable to members who utilize the Scheme's DSP Optometrists only Limited to one pair of spectacles per beneficiary every 24 months	100% of DSP Tariff* R221 per lens – clear single vision or R467 per lens – clear bifocal or R467 per lens – base multifocal No benefit for contact lenses if spectacles purchased	No benefits	100% of DSP Tariff* R221 per lens – clear single vision or R467 per lens – clear bifocal or R467 per lens – base multifocal No benefit for contact lenses if spectacles purchased	100% of DSP
3.2. Contact Lenses: In Network ONLY Benefit applicable to members who utilize the Scheme's DSP network optometrist only One claim per beneficiary every 24 months Subject to optical protocol	100% of DSP Tariff* R677 per beneficiary every 24 months No benefit for spectacles if contact lenses purchased. Provider Network Only	No benefits	100% of DSP Tariff* Paid from Risk Pool R1 045 per beneficiary every 24 months. No benefit for spectacles if contact lenses purchased.	Contact Lens: R1 456
3.2. Frames/Lens Enhancements: In Network ONLY A frame cannot be claimed alone or with contact lenses. Benefit applicable to members who utilize the Scheme's DSP network optometrist only One claim per beneficiary every 24 months	100% of DSP Tariff* R315 per beneficiary	No benefits	100% of DSP Tariff* Paid from Risk Pool R575 per Frame	Frames: R660 Single vision Lens: R212 per lens Bi-Focal Lens: R460 per lens Multi Focal Lens : R460 per lens
3.2. Eye Tests: In Network Benefit applicable to members who utilize the Scheme's DSP network optometrist only One claim per beneficiary every 24 months	100% of DSP Tariff* One comprehensive consultation per beneficiary every 24 months	No benefits	100% of DSP Tariff* Paid from Risk Pool One comprehensive consultation per beneficiary every 24 months	One (1) test per beneficiary per 24 months

OPTICAL BENEFITS

3. Optical Benefits Benefit applicable to members who utilize the Scheme's DSP network optometrist only, Paid from Risk				
	Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
3.1. Spectacle Lenses: In Network ONLY Benefit applicable to members who utilize the Scheme's DSP Optometrists only Limited to one pair of spectacles per beneficiary every 24 months	100% of DSP Tariff* R221per lens – clear single vision or R467per lens – clear bifocal or R467per lens – base multifocal No benefit for contact lenses if spectacles purchased	100% of DSP R212 per lens - Single vision Lens R460 per lens - Bi-Focal Lens R844 per lens - Multi Focal Lens No benefit for spectacles if contact lenses purchased.	100% of DSP Tariff* R221 per lens – clear single vision or R467 per lens – clear bifocal or R809 per lens – base multifocal Fixed tints up to 35% No benefit for contact lenses if spectacles purchased	100% of DSP Tariff* R212 per Single vision lens or R460 per Bi-Focal lens or R844 per Multi-Focal lens No benefit for spectacles if contact lenses purchased.
3.2. Contact Lenses: In Network ONLY Benefit applicable to members who utilize the Scheme's DSP network optometrist only One claim per beneficiary every 24 months Subject to optical protocol	100% of DSP Tariff* R1 901 per beneficiary every 24 months No benefit for spectacles if contact lenses purchased.	100% of DSP Tariff*. Limited to R1 825 per beneficiary per 24 months	100% of DSP Tariff* R3 061 per beneficiary every 24 months No benefit for spectacles if contact lenses purchased.	100% of DSP Tariff* R2 083 per beneficiary every 24 months No benefit for spectacles if contact lenses purchased.
3.2. Frames/Lens Enhancements: In Network ONLY A frame cannot be claimed alone or with contact lenses. Benefit applicable to members who utilize the Scheme's DSP network optometrist only One claim per beneficiary every 24 months	100% of DSP Tariff* R835 per beneficiary	100% of DSP Tariff*. Frames R1 007 per beneficiary.	100% of DSP* Tariff R1 292 per beneficiary.	100% of DSP* Tariff R2 083 per beneficiary.
3.2. Eye Tests: In Network Benefit applicable to members who utilize the Scheme's DSP network optometrist only One claim per beneficiary every 24 months	100% of DSP Tariff* One comprehensive consultation per beneficiary every 24 months	One (1) test per beneficiary per 24 months 100% Scheme Tariff*. Refractive Surgery Including Radial Keratotomy R7 655per family per year	100% of DSP* Tariff One comprehensive consultation per beneficiary every 24 months	100% of DSP* Tariff One comprehensive consultation per beneficiary every 24 months 100% of Sizwe Hosmed rate – a limit of R20 894 per family per annum

DENTISTRY BENEFITS

	Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
4. Dentistry Benefits - Benefit applicable to members who utilize the Scheme's DSP network Only. Paid from Risk				
4.1. Conservative (Basic) Dentistry (Dentist and Dental therapist)	100% of Scheme Tariff*	No benefit subject to PMBs	100% of Scheme Tariff*	100% of Scheme Tariff
Conscious sedation: (limited to beneficiaries below the age of 16 years)	Conscious sedation: Extensive dental treatment (more than 4 fillings or extractions) subject to dental treatment protocols and pre-authorisation		Conscious sedation: Extensive dental treatment (more than 4 fillings or extractions) subject to dental treatment protocols and pre-authorisation	Inhalation sedation: 100% of the Sizwe Hosmed rate; subject to managed care protocols.
Consultations, Fillings, Extractions	Yes		Yes (Paid from Risk Pool)	Two (2) annual check-ups per beneficiary (once in six (6) months) Fillings: once per tooth in 720 days.
Root Canal treatment included in conservative dentistry	No benefit		No benefit	Subject to managed care protocols. Excluding wisdom teeth (3rd molars) and primary (milk) teeth
Preventative scale and polish	Yes		Yes	Two (2) annual scale and polish treatments per beneficiary (once in 6 months)
Infection control	Yes		Yes	100% Scheme Tariff
Fluoride treatment (limited to beneficiaries below the age of 12 years)	Yes		Yes	Fissure sealants is limited to beneficiaries younger than 16 years of age
Dental X-rays	X-rays (limited to intra-oral) Dental protocols apply and pre-authorisation required for extensive treatment plans Quantity limitations apply Contracted Network Provider Only		X-rays (limited to intra-oral) Dental protocols apply and pre-authorisation required for extensive treatment plans Quantity limitations apply Contracted Network Provider Only	Limited to beneficiaries from age 5 up to the age of 13 years Intra-oral: subject to managed care protocols. Panoramic radiographs limited to 1 per beneficiary every 24 months Extra-oral: one (1) scan per beneficiary in a two (2) year period

DENTISTRY BENEFITS

4. Dentistry Benefits - Benefit applicable to members who utilize the Scheme's DSP network Only. Paid from Risk				
	Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
4.1. Conservative (Basic) Dentistry (Dentist and Dental therapist) Conscious sedation: (limited to beneficiaries below the age of 16 years) Consultations, Fillings, Extractions Root Canal treatment included in conservative dentistry Preventative scale and polish Infection control Fluoride treatment (limited to beneficiaries below the age of 12 years) Dental X-rays	100% of Scheme Tariff* R6 956 per family per annum. Limited to R4 872 per beneficiary Two (2) implants/family/ annum over a 5 year period with a limit of R16 380 One (1) set per beneficiary every 5 years. Subject to advanced dentistry limit. One (1) per beneficiary every 4 years. Subject to advanced dentistry limit	100% of Scheme Tariff* subject to pre-authorisation and managed care protocols Crowns and bridges: Pre-authorisation is required. 1 crown per family per year Once per tooth in a 5-year period. Dental implants: No benefits Orthodontics: Pre-authorisation is required. A 35% co-payment is applicable. Benefit for fixed comprehensive treatment is limited to individuals from age 9 up to the age of 21 years of age. Subject to registration on the Periodontal Programme Limited to conservative, non-surgical therapy only (root planning) Surgical periodontics: No benefit Plastic dentures: One set of plastic dentures, full or partial (an upper and a lower) per beneficiary in a 4-year period, subject to pre-authorisation Partial chrome cobalt dentures: 2 partial frames (an upper and a lower) per beneficiary in a 5-year period,	100% of Scheme Tariff* R7 434 per beneficiary limited to R9 371 per family per annum Two (2) implants/family/ annum over a 5 year period with a limit of R16 380,00 Limited to one (1) set per beneficiary every 5 years. Subject to advanced dentistry limit. Limited to 1 per beneficiary every 4 years. Subject to availability of benefits	100% of Scheme Tariff* Crowns and bridges: Pre-authorisation is required. 3 crowns per family per year, once per tooth in a 5-year period Dental implants: 2 Implants per beneficiary per annum over a period of 5 years limited to R16 380 Benefit for fixed comprehensive treatment is limited to individuals from age 9 to younger than 21 years of age. Subject to registration on the Periodontal Programme Limited to conservative, non-surgical therapy only (root planning) Surgical periodontics: No benefits Partial chrome cobalt dentures: 2 partial frames (an upper and a lower) per beneficiary in a 5-year period, limited to 2 family members per year Plastic dentures: One set of plastic dentures, full or partial (an upper and a lower) per beneficiary in a 4-year period, subject to pre-authorisation

DENTISTRY BENEFITS

	Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
4.2. Advanced Dentistry (e.g. Crowns & Bridgework, Dentures, Orthodontics, removal of impacted wisdom teeth and Non-Surgical Periodontics): Orthodontics for beneficiaries up to the age of 21 years	100% of Scheme Tariff* Limited to PMBs		Non-PMBs Paid from MSA* All clinically valid specialised dental treatment covered from MSA*	100% of Scheme Tariff* subject to pre-authorisation and managed care protocols (Excluding Partial metal frame dentures, Crowns and bridges, Implants, Orthodontics.
Dental Implants	No benefit		No benefit	No benefit
Partial Metal Frame Dentures (Limited to beneficiaries above the age of 16 years)	No benefit		No benefit	Periodontics: 100% of Scheme Tariff ; subject to registration on the Periodontal Programme. Limited to conservative, non-surgical therapy only (root planning) (Excluding Surgical periodontics).
Acrylic (Plastic) Dentures: (Limited to beneficiaries above the age of 16 years)	1 set of Acrylic/plastic dentures per beneficiary every 4 years. Repairs, realigning and repairing of Dentures every 12 months Limited to PMB. Contracted Network Provider only		1 set of Acrylic (plastic) denture per beneficiary every 4 years. Repairs, realigning and repairing of dentures every 12 months. Limited to PMBs	One (1) set of plastic dentures, full or partial (an upper and a lower) per beneficiary in a four (4) year period
4.3. Maxillo-Facial & Oral, including Dental Surgery (Consultations, Surgical procedures and Operations) Subject to PMB's, pre-authorisation and protocols.	100% of Scheme Tariff* Limited to PMBs		100% of Scheme Tariff* Limited to PMBs	100% of Scheme Tariff*, subject to managed care protocols Benefit for Temporo-mandibular Joint (TMJ) therapy is limited to non-surgical intervention/ treatments. The claims for oral pathology procedures (cysts and biopsies, the surgical treatment of tumours of the jaw and soft tissue tumours) will only be covered if supported by a laboratory report that confirms diagnosis.

DENTISTRY BENEFITS

	Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
4.2. Advanced Dentistry (e.g. Crowns & Bridgework, Dentures, Orthodontics, removal of impacted wisdom teeth and Non-Surgical Periodontics): Orthodontics for beneficiaries up to the age of 21 years	100% of Scheme Tariff* R6 956 per family per annum. Limited to R4 872 per beneficiary	100% of Scheme Tariff* subject to pre-authorisation and managed care protocols Crowns and bridges: Pre-authorisation is required. 1 crown per family per year Once per tooth in a 5-year period.	100% of Scheme Tariff* R7 434 per beneficiary limited to R9 371 per family per annum,	100% of Scheme Tariff* Crowns and bridges: Pre-authorisation is required. 3 crowns per family per year, once per tooth in a 5-year period
Dental Implants	Two (2) implants/family/ annum over a 5 year period with a limit of R16 380	Dental implants: No benefits Orthodontics: Pre-authorisation is required. A 35% co-payment is applicable. Benefit for fixed comprehensive treatment is limited to individuals from age 9 up to the age of 21 years of age.	Two (2) implants/family/ annum over a 5 year period with a limit of R16 380,00	Dental implants: 2 Implants per beneficiary per annum over a period of 5 years limited to R16 380 Benefit for fixed comprehensive treatment is limited to individuals from age 9 to younger than 21 years of age.
Partial Metal Frame Dentures (Limited to beneficiaries above the age of 16 years)	One (1) set per beneficiary every 5 years. Subject to advanced dentistry limit.	Subject to registration on the Periodontal Programme Limited to conservative, non-surgical therapy only (root planning) Surgical periodontics: No benefit	Limited to one (1) set per beneficiary every 5 years. Subject to advanced dentistry limit.	Subject to registration on the Periodontal Programme Limited to conservative, non-surgical therapy only (root planning) Surgical periodontics: No benefits Partial chrome cobalt dentures: 2 partial frames (an upper and a lower) per beneficiary in a 5-year period, limited to 2 family members per year
Acrylic (Plastic) Dentures: (Limited to beneficiaries above the age of 16 years)	One (1) per beneficiary every 4 years. Subject to advanced dentistry limit	Plastic dentures: One set of plastic dentures, full or partial (an upper and a lower) per beneficiary in a 4-year period, subject to pre-authorisation Partial chrome cobalt dentures: 2 partial frames (an upper and a lower) per beneficiary in a 5-year period,	Limited to 1 per beneficiary every 4 years. Subject to availability of benefits	Plastic dentures: One set of plastic dentures, full or partial (an upper and a lower) per beneficiary in a 4-year period, subject to pre-authorisation
4.3. Maxillo-Facial & Oral, including Dental Surgery (Consultations, Surgical procedures and Operations) Subject to PMB's, pre-authorisation and protocols.	100% of Scheme Tariff* Benefit is payable from hospitalisation in cases of accidents, injury, congenital abnormalities and oncology related procedures only	100% of Scheme Tariff*, subject to managed care protocols Benefit for Temporo-mandibular Joint (TMJ) therapy is limited to non-surgical intervention/ treatments. The claims for oral pathology procedures (cysts and biopsies, the surgical treatment of tumours of the jaw and soft tissue tumours) will only be covered if supported by a laboratory report that confirms diagnosis.	100% of Scheme Tariff* Benefit is payable from hospitalisation in cases of accidents, injury, congenital abnormalities and oncology related procedures only.	100% of Scheme Tariff* Benefit for Temporo-Mandibular Joint (TMJ) therapy is limited to non-surgical intervention/ treatments. The claims for oral pathology procedures (cysts and biopsies, the surgical treatment of tumours of the jaw and soft tissue tumours) will only be covered if supported by a laboratory report that confirms diagnosis

AUXILIARY BENEFITS

	Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
5. Auxiliary Benefit – Part of Overall Day-to-Day benefits				
5.1. Alternative Services Includes: Speech therapy, podiatry, occupational therapy, social worker, dietetics, audiology, naturopathy, podiatry, educational psychologist, biokinetics and registered counsellor etc. **Subject to PMBs and Protocols**	No benefit		100% of Scheme Tariff* Non-PMBs paid from MSA* Medicine dispensed limited to Acute Medication Limit (3.1). Homeopathic Medication Excluded	100% of Scheme Tariff*, Includes: Speech therapy, podiatry, occupational therapy, social worker, dietetics, audiology, homeopathy, clinical technologist, educational psychologist, biokinetics and registered counsellor, subject to the limits below M: R1 230 M+: R1 976 Chiropractors : Payable at of Scheme Tariff up to a limit of R1 219 per beneficiary per annum
5.2. Remedial And Other Therapies Audiology, Speech therapy, Dieticians, Hearing Aid Acousticians, Occupational Therapy, Orthotics, Social Workers and Speech Therapy	100% of Scheme Tariff* Limited to PMBs		100% of Scheme Tariff* Collectively limited to R2 730 per family per annum	
5.3. Physiotherapy Out Of Hospital Biokinetics & Physiotherapy	100% of Scheme Tariff* Limited to PMB conditions only and clinical protocols Cardiac and Respiratory conditions: Subject to provision of treatment plan and therapy goals. Maximum of 6 sessions per beneficiary, thereafter subject to progress report and evidence of response.		100% of Scheme Tariff* Subject to PMB conditions and clinical protocols Non-PMBs paid from MSA* Cardiac and Respiratory conditions: Subject to provision of treatment plan and therapy goals. Maximum of 6 sessions per beneficiary, thereafter subject to progress report and evidence of response.	100% of Scheme Tariff*. subject to pre-authorisation, managed care rules and clinical protocols.

AUXILIARY BENEFITS

	Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
5. Auxiliary Benefit – Part of Overall Day-to-Day benefits				
5.1. Alternative Services Includes: Speech therapy, podiatry, occupational therapy, social worker, dietetics, audiology, naturopathy, podiatry, educational psychologist, biokinetics and registered counsellor etc. **Subject to PMBs and Protocols**	100% of Scheme Tariff* Collectively limited to R4 106per family per annum Medicine dispensed limited to Acute Medication Limit No benefit	100% of Scheme Tariff*. Paid from available savings and/ or above threshold benefit, limited to: M: R1 827 M+: R3 205 Associated Services. Chiropractic and Homeopathy Treatment 100% Scheme Tariff*. Paid from available savings and/or above threshold benefit Limited to R1 575 per beneficiary per annum	100% of Scheme Tariff* Collectively limited to R4 457 per family per annum Medicine dispensed limited to Acute	100% of Scheme Tariff*. Paid from available MSA and/ or above threshold benefit, subject to the limits below: M: R3 356 M+: R5 654 Chiropractors : Payable at of Scheme Tariff up to a limit of R2 426 per beneficiary per annum Chiropractic and Homeopathy Treatment 100% Scheme Tariff*. Paid from available savings and/or above threshold benefit Limited to R2 425 per beneficiary per annum.
5.2. Remedial And Other Therapies Audiology, Speech therapy, Dieticians, Hearing Aid Acousticians, Occupational Therapy, Orthotics, Social Workers and Speech Therapy	100% of Scheme Tariff* Collectively limited to R3 959 per family per annum	100% of Scheme Tariff subject to pre–authorisation and PMBs Limited to speech therapy; podiatry; occupational therapy; social worker; dietetics; audiology, homeopathy; educational psychologist; biokinetist and registered counsellor Clinical and Medical Technologist 100% Scheme Tariff*. Paid from available savings and/or above threshold benefit	100% of Scheme Tariff* Collectively limited to R5 644 per family per annum	100% of Scheme Tariff* Collectively limited to R5 375 per family per annum Clinical and Medical Technologist 100% Scheme Tariff*. Paid from available MSA and/or above threshold benefit
5.3. Physiotherapy Out Of Hospital Biokinetics & Physiotherapy	100% of Scheme Tariff* R3 077 per family per annum. Limited to R1 869 per beneficiary per annum	100% of Scheme Tariff*. Paid from available savings and/or above threshold benefit	100% of Scheme Tariff* R2 982 per beneficiary limited to R4 772 per family per annum.	100% of Scheme Tariff* Paid from available MSA and/or above threshold benefit. Above threshold benefit limited to: R15 000 per family per annum Subject to pre-authorisation, managed care rules and clinical protocols. Subject to the limit set out in the day-to-day benefits. PMB applicable

MEDICAL APPLIANCE BENEFITS

Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
6. Medical Appliances – Part of Overall Day-to-Day benefits			
Appliances **E.g. Hearing Aids, Wheelchairs and callipers etc.** **Subject to pre-authorisation**	100% of Negotiated Tariff* Limited to R2 137 per family per annum In and Out of Hospital Limited to PMB conditions only • Blood Pressure Monitors Subject to a sub-limit of R599 for beneficiaries registered for Hypertension		100% of Negotiated Tariff* In & Out of Hospital – PMBs only Limited to R7 130 per family per annum Paid from Risk Pool subject to sub limit • Blood Pressure Monitors Subject to a sub-limit of R599 for beneficiaries registered for Hypertension	100% of Negotiated Tariff* Benefit M: R1 230 M+: R1 976 (includes procurement of Nebulizer, Glucometer, Insulin pump, Morphine pump, C-PAP machine) Any appliance is payable only once per annum, subject to the limits as stipulated above. The cost of C-PAP machines is payable from this benefit, subject to fulfilment of clinical criteria and procurement protocols Hearing Aids: 100% of Negotiated Tariff, subject to an annual limit of R18 182 per family One (1) pair of hearing unit (one per ear) per beneficiary every four (4) years from date of acquisition, subject to pre-authorisation Non-motorised wheelchairs: One per family every 4-year cycle Family Limit: R2 275

MEDICAL APPLIANCE BENEFITS

	Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
6. Medical Appliances – Part of Overall Day-to-Day benefits				
Appliances **E.g. Hearing Aids, Wheelchairs and callipers etc.** **Subject to pre-authorisation**	100% of Negotiated Tariff* Limited to R15 299 per family per annum • Stoma Care – Subject to a sub limit of R7 896 per family per annum • Wheelchairs – one claim per Beneficiary every 36 months subject to pre-authorisation. • Hearing aids – one claim per beneficiary every 24 months subject to pre-authorisation. • Blood Pressure Monitors Subject to a sub-limit of R599 for beneficiaries registered for Hypertension Subject to overall prosthesis limit. Children under 7 years of age only.	100% of Negotiated Tariff*. Paid from available savings and/or above threshold benefit Limited to: M: R1 827 M+: R3 206 (includes procurement of Nebulizer, Glucometer, Insulin pump, Morphine pump, C-PAP machine) Any appliance is payable only once per annum, subject to the limits as stipulated above. The cost of C-PAP machines is payable from this benefit, subject to fulfilment of clinical criteria and procurement protocols Hearing Aids: 100% of Negotiated Tariff, Paid from Risk. Subject to an annual limit of R29 102 per family One (1) pair of hearing unit (one per ear) per beneficiary every three (3) years from date of acquisition, Non-motorised wheelchairs – one per family every 4-year cycle. Family Limit: R3 816 Paid from Risk	100% of Negotiated Tariff* Limited to R16 097 per family per annum • Stoma Care – Subject to a sub limit of R8 279 per family per annum • Wheelchairs – one claim per Beneficiary every 36 months subject to pre-authorisation. • Hearing aids – one claim per beneficiary every 24 months subject to pre-authorisation • Blood Pressure Monitors Subject to a sub-limit of R599 for beneficiaries registered for Hypertension	100% of Negotiated Tariff*. Paid from available MSA and/or above threshold benefit M: R3 201 M+: R5 333 (includes procurement of Nebulizer, Glucometer, Insulin pump, Morphine pump, C-PAP machine) Any appliance is payable only once per annum, subject to the limits as stipulated above. The cost of C-PAP machines is payable from this benefit, subject to fulfilment of clinical criteria and procurement protocols Hearing Aids: 100% of Negotiated Tariff. Paid from Risk Subject to an annual limit of R43 650 per family One (1) pair of hearing unit (one per ear) per beneficiary every three (3) years from date of acquisition, subject to pre-authorisation Non-motorised wheelchairs – one per family every 4-year cycle. Paid from Risk Family Limit: R5 321

OTHER BENEFITS

7. Other Benefits	Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
7.1. Air/Road Ambulance & Emergency Services **The Schemes preferred provider must be contacted should you require an Ambulance – failure to adhere to this could result in you being held liable for costs incurred.**	100% of Negotiated Tariff* 24-hour access to Call Centre including telephonic Nurse advise line Emergency: Subject to pre-authorisation within 72 hours after the emergency. Inter-hospital transfers must be done by preferred provider only. • Emergency response by road or air to scene of incident and Transfer from scene, to closest, most appropriate facility • Escort return of stranded minors can be arranged Non-emergency: Subject to pre-authorisation beforehand. • Facilitation of medically justified inter-facility transfers • Medical repatriation	100% negotiated Tariff* Ambulance and Emergency Services Subject to pre-authorisation, Scheme protocols and the use of a Designated Service provider- Europ Assistance (EA) Pre-authorisation must be obtained from Europ Assistance within 72 hours shout an ambulance ne required to transport you to a health facility. 0860 11 7799	100% of Negotiated Tariff* 24-hour access to Call Centre including telephonic Nurse advise line Emergency: Subject to pre-authorisation within 72 hours after the emergency. Inter-hospital transfers must be done by preferred provider only. • Emergency response by road or air to scene of incident and Transfer from scene, to closest, most appropriate facility • Escort return of stranded minors can be arranged Non-emergency: Subject to pre-authorisation beforehand. • Facilitation of medically justified inter-facility transfers • Medical repatriation	100% of Negotiated Tariff* as authorised by the contracted service provider. Authorisation for emergency transportation should be obtained within 72 hours. If services are not pre-authorised through the preferred provider, claims will not qualify for payment
7.2. Psychology & Psychiatry Treatment **Subject to PMB's and referral from GP or Specialist, failure to do so will result in no payment.** **Subject to confirmed diagnosis, treatment plan and managed care protocols**	Limited to PMBs only		100% of Negotiated Tariff* Subject to PMB conditions only Non-PMBs paid from MSA*	100% of Scheme Tariff*. Limited to Psychiatrists, Clinical and Counselling Psychologists for mental health disorders. Limited to R6 276 per family
7.3. Infertility **Subject to PMBs, pre-authorisation and protocols.**	Limited to PMBs only		100% of Negotiated Tariff* Non-PMBs paid from MSA*	Covered in accordance with Code 902 M of the PMB Regulations. All investigations for an infertility condition will be covered in a DSP hospital and in accordance with the policies of the relevant Public Authorities
7.4 Hospice and Private Nursing **Subject to PMB's, pre-authorisation and protocols.**	100% of Negotiated Tariff* Limited to PMBs only		100% of Negotiated Tariff* Limited to PMBs only Non-PMBs subject to MSA*	100% of Negotiated Tariff for all services rendered at registered step-down facilities, nursing facilities Subject to the Hospital Benefit Management Programme and the Disease Management Programme. R5 505 per family

OTHER BENEFITS

7. Other Benefits	Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
7.1. Air/Road Ambulance & Emergency Services **The Schemes preferred provider must be contacted should you require an Ambulance – failure to adhere to this could result in you being held liable for costs incurred.**	100% of Negotiated Tariff* 24-hour access to Call Centre including telephonic Nurse advise line Emergency: Subject to pre-authorisation within 72 hours after the emergency. Inter-hospital transfers must be done by preferred provider only. • Emergency response by road or air to scene of incident and Transfer from scene, to closest, most appropriate facility • Escort return of stranded minors can be arranged Non-emergency: Subject to pre-authorisation beforehand. • Facilitation of medically justified inter-facility transfers • Medical repatriation	100% of Negotiated Tariff* 24-hour access to Call Centre including telephonic Nurse advise line Emergency: Subject to pre-authorisation within 72 hours after the emergency. Inter-hospital transfers must be done by preferred provider only. • Emergency response by road or air to scene of incident and Transfer from scene, to closest, most appropriate facility • Escort return of stranded minors can be arranged Non-emergency: Subject to pre-authorisation beforehand. • Facilitation of medically justified inter-facility transfers • Medical repatriation	100% of Negotiated Tariff* 24-hour access to Call Centre including telephonic Nurse advise line Emergency: Subject to pre-authorisation within 72 hours after the emergency. Inter-hospital transfers must be done by preferred provider only. • Emergency response by road or air to scene of incident and Transfer from scene, to closest, most appropriate facility • Escort return of stranded minors can be arranged Non-emergency: Subject to pre-authorisation beforehand. • Facilitation of medically justified inter-facility transfers • Medical repatriation	100% of Negotiated Tariff* 24-hour access to Call Centre including telephonic Nurse advise line Emergency: Subject to pre-authorisation within 72 hours after the emergency. Inter-hospital transfers must be done by preferred provider only. • Emergency response by road or air to scene of incident and Transfer from scene, to closest, most appropriate facility • Escort return of stranded minors can be arranged Non-emergency: Subject to pre-authorisation beforehand. • Facilitation of medically justified inter-facility transfers • Medical repatriation
7.2. Psychology & Psychiatry Treatment **Subject to PMB's and referral from GP or Specialist, failure to do so will result in no payment.** **Subject to confirmed diagnosis, treatment plan and managed care protocols**	100% of Scheme Tariff* R8 101 per Family per annum Limited to R3 224 per beneficiary per annum	100% of Scheme Tariff* - Paid from Risk Limited to Psychiatrists, Clinical and Counselling Psychologists for mental health disorders. Limited to R10 001 per family	100% of Scheme Tariff* R5 219 per beneficiary, Limited to R10 437 per Family.	100% of Scheme Tariff*. Paid from Risk Limited to Psychiatrists, Clinical and Counselling Psychologists for mental health disorders. Limited to R20 056 per family
7.3. Infertility **Subject to PMBs, pre-authorisation and protocols.**	100% of Scheme Tariff*	Covered in accordance with Code 902 M of the PMB Regulations. All investigations for an infertility condition will be covered in a DSP hospital and in accordance with the policies of the relevant Public Authorities	100% of Scheme Tariff*	100% of Scheme Tariff* All investigations for an infertility condition will be covered in a DSP hospital and in accordance with the policies of the relevant Public Authorities
7.4 Hospice and Private Nursing **Subject to PMB's, pre-authorisation and protocols.**	100% of Negotiated Tariff* Subject to combined limit of a maximum period of 14 days per annum-except for PMB's	100% of Negotiated Tariff for all services rendered at registered step-down facilities, nursing facilities Subject to the Hospital Benefit Management Programme and the Disease Management Programme. Private Nurse: Frail care is not a covered benefit. Limit per year per family – R8 217 PMB applicable	100% of Negotiated Tariff* Subject to combined limit of a maximum period of 14 days per annum-except for PMBs	100% of Negotiated Tariff for all services rendered at registered step-down facilities, nursing facilities Subject to the Hospital Benefit Management Programme and the Disease Management Programme. Private Nurse: Frail care is not a covered benefit. Limit per year per family – R11 010 PMB applicable

SIZWE HOSMED BAMBINO BENEFITS

	Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
8. Sizwe Hosmed Bambino Programme **Sizwe Hosmed cares about its maternity mothers and this programme aims to assist them during their pregnancy by providing advice and benefits. At 24 weeks of maternity the Scheme offers a free maternity bag with baby goodies, to pregnant women registered on the Bambino Programme.**				
8.1. Sizwe Hosmed Bambino Programme. Subject to Registration on Sizwe Hosmed Bambino Programme, PMBs and protocols.	100% of Scheme Tariff*	100% of Scheme Tariff*	100% of Scheme Tariff*	100% of Scheme Tariff*
8.2. Hospital Confinement **8.3. Home Delivery: By Registered Midwife pre-authorisation required**	Admissions only at DSP* Hospital Network. NVD – Limited to 2 days Caesarean – Limited to 3 days	100% Negotiated Tariff*	Admissions only at DSP* Hospital Network. NVD – Limited to 2 days Caesarean – Limited to 3 days 100% of Negotiated Tariff*	NVD – Limited to 2 days Caesarean – Limited to 3 days 100% of cost for the delivery by a general practitioner, medical specialist or midwife and materials supplied
8.4. Maternity Ultrasounds(s): **8.5. Maternity Visit(s):**	100% of Negotiated Tariff* Limited to two 2 x 2D ultrasounds per pregnancy for In and Out of Hospital 100% of Scheme Tariff* Subject to DSP* GP and Specialist consultation limit	Limited to nine (9) antenatal consultations by a GP or midwife plus two (2) antenatal specialist consultations subject to GP referral Two (2) 2D scans	Limited to three 3 x 2D ultrasounds per pregnancy for In and Out of Hospital Additional 7 GP maternity consultations and 2 specialist consultations per Pregnancy at GP or Specialist (Once these limits have been reached further ante-natal consultations will be paid from the day-to-day benefit)	2) x 2D scans per pregnancy 9 additional maternity consultations during pregnancy. 6 of which are for GP or Midwife, and 3 for a Specialist obstetrician
8.6. Antenatal Pathology Screening: Haemoglobin, Syphilis, Chlamydia, Bacteriuria, Hepatitis B and Rhesus incompatibility	100% of Scheme Tariff*	One (1): Full Blood Count Two (2): Haemoglobin One (1): Blood Grouping One (1)VDRL Two (2); HIV Twelve (12): Urine analysis	100% of Scheme Tariff*	(2) x Heamoglobin Measurement test (1) x Blood Grouping test. (1) x VDRL test for Syphilis. (2) x HIV blood tests (12) x urine analysis tests (1) x Full blood count (FBC) test
8.7. Vitamins		Limited to R120		Vitamins R120 subject to Day to Day benefit
8.8. Antenatal Classes: By Registered Nurse	No benefit	No benefit	No benefit	No benefit
8.9. Immunisation benefit	Immunisation as per the Immunisation schedule by the Department of Health up to 6 years of age	Immunisation as per the Immunisation schedule by the Department of Health up to 6 years of age	Immunisation as per the Immunisation schedule by the Department of Health up to 6 years of age	Immunisation as per the Immunisation schedule by the Department of Health up to 6 years of age

SIZWE HOSMED BAMBINO BENEFITS

Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive

8. Sizwe Hosmed Bambino Programme Sizwe Hosmed cares about its maternity mothers and this programme aims to assist them during their pregnancy by providing advice and benefits. At 24 weeks of maternity the Scheme offers a free maternity bag with baby goodies, to pregnant women registered on the Bambino Programme.				
8.1. Sizwe Hosmed Bambino Programme. Subject to Registration on Sizwe Hosmed Bambino Programme, PMBs and protocols.	100% of Scheme Tariff* PMB Based on Clinical Protocols	100% of Scheme Tariff*	100% of Scheme Tariff* PMB Based on Clinical Protocols	100% of Scheme Tariff* Subject to registration on the Maternity Programme.
8.2. Hospital Confinement	NVD – Limited to 2 days Caesarean – Limited to 3 days	NVD – Limited to 2 days Caesarean – Limited to 3 days 100% of cost for the delivery by a general practitioner, medical specialist or midwife and materials supplied	NVD – Limited to 2 days Caesarean – Limited to 4 days	100% of cost for accommodation at general ward rates, theatre fees, labour ward fees, drugs, dressings, medicines and materials in a private or provincial hospital and 100% of the cost for drugs, dressings, medicines and materials supplied by a midwife. Delivery: 100% of the cost for the delivery by a general practitioner, medical specialist or midwife and materials supplied.
8.3. Home Delivery: By Registered Midwife pre-authorisation required	100% of Negotiated Tariff*		100% of Negotiated Tariff*	
8.4. Maternity Ultrasounds(s):	Limited to three (3) 2D ultrasounds per pregnancy for In and Out of Hospital	2 x 2D scans per pregnancy	Limited to three 2 x 2D ultrasounds per pregnancy and 1 x 3D ultrasound for In and Out of Hospital	2 x 2D scans per pregnancy, excluding the diagnostic sonar. Scans paid at 2D rates as per negotiated rates with the provider
8.5. Maternity Visit(s):	Additional 6 GP consultations and 3 specialist consultations per Pregnancy at GP or Specialist	9 additional maternity consultations during pregnancy. 6 of which are for a GP, Midwife and 3 for a Specialist Obstetrician visits	Additional 6 GP maternity consultations and 3 specialist consultations per pregnancy Limited to R604 per mother per annum	9 additional maternity consultations during pregnancy. 6 of which are for GP, Midwife and 3 for a Specialist. obstetrician visits per pregnancy at referral by the GP or midwife, over and above the regular specialist benefits.
8.6. Antenatal Pathology Screening: Haemoglobin, Syphilis, Chlamydia, Bacteriuria, Hepatitis B and Rhesus incompatibility	100% of Scheme Tariff*	Two (2) x Heamoglobin Measurement test One (1) x Blood Grouping test. One (1) x VDRL test for Syphilis. Two (2) x HIV blood tests Twelve (12) x urine analysis tests One (1) x Full blood count (FBC) test	100% of Scheme Tariff*	Two (2) x Heamoglobin Measurement test One (1) x Blood Grouping test. One (1) x VDRL test for Syphilis. Two (2) x HIV blood tests Twelve (12) x urine analysis tests One (1) x Full blood count (FBC) test
8.7. Vitamins	R120 – subject to Day-to-Day limit	R120 – subject to Day-to-Day limit	Vitamins R120 subject to Day to Day benefit.	Vitamins R120 subject to Day to Day benefit.
8.8. Antenatal Classes: By Registered Nurse	No benefit	No benefit	No benefit	No benefit
8.9. Immunisation benefit	Immunisation as per the Immunisation schedule by the Department of Health up to 6 years of age	Immunisation as per the Immunisation schedule by the Department of Health up to 6 years of age	Immunisation as per the Immunisation schedule by the Department of Health up to 6 years of age	Immunisation as per the Immunisation schedule by the Department of Health up to 6 years of age

PREVENTATIVE CARE BENEFITS

Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
9. Preventative Care Benefits			
9.1. Preventative Care Screening	100% of Scheme Tariff* • Wellness consultation – R1 219 per family per annum • Free COVID-19 Vaccination per beneficiary • Diabetic Eye Care • 1 Free Pap Smear for Females over 18 Years per beneficiary per Annum • 1 Free Mammogram for Females over 40 Years per beneficiary per Annum • 1 Free PSA for Males over 40 Years per beneficiary per Annum • 1 Free Cholesterol Test over 20 Years per beneficiary per Annum • 1 Free Flu Vaccine per beneficiary per Annum • 1 Free Blood Sugar Test over 15 Years per beneficiary per Annum • 1 Free Colon Cancer Blood Test over 50 years per beneficiary per Annum • 1 Free Blood Pressure test per beneficiary per Annum • 1 Free HIV Test per beneficiary per Annum • 1 Free HPV vaccination per beneficiary between 9 and 12 years of age 1 Free Pneumococcal Vaccine per beneficiary above 65 Years of age per Annum • 1 Free Bone density per annum: Women from 50 years up to 69 years of age. Males at 65 years of age	100% of Scheme Tariff* • Wellness consultations – R1 219 per family per annum • Free COVID-19 Vaccination per beneficiary • Diabetic Eye Care • 1 Free Pap Smear for Females over 18 Years per beneficiary per Annum • 1 Free Mammogram for Females over 40 Years per beneficiary per Annum • 1 Free PSA for Males over 40 Years per beneficiary per Annum • 1 Free Cholesterol Test over 20 Years per beneficiary per Annum • 1 Free Flu Vaccine per beneficiary per Annum • 1 Free Blood Sugar Test over 15 Years per beneficiary per Annum • 1 Free Colon Cancer Blood Test over 50 years per beneficiary per Annum • 1 Free Blood Pressure test per beneficiary per Annum • 1 Free HIV Test per beneficiary per Annum • 1 Free HPV vaccination per beneficiary between 9 and 12 years of age • 1 Free Pneumococcal Vaccine per beneficiary above 65 Years of age per Annum • Immunisation for children six (6) years old and younger, In line with those provided by the Department of Health subject to Wellness screening family limit • 1 Free Bone density per annum: Women from 50 years up to 69 years of age. Males at 65 years of age	100% of Scheme Tariff* • Wellness consultation – R1 219 per family per annum • Free COVID-19 Vaccination per beneficiary • Diabetic Eye Care • 1 Free Pap Smear for Females over 18 Years per beneficiary per Annum • 1 Free Mammogram for Females over 40 Years per beneficiary per Annum • 1 Free PSA for Males over 40 Years per beneficiary per Annum • 1 Free Cholesterol Test over 20 Years per beneficiary per Annum • 1 Free Flu Vaccine per beneficiary per Annum • 1 Free Blood Sugar Test over 15 Years per beneficiary per Annum • 1 Free Colon Cancer Blood Test over 50 years per beneficiary per Annum • 1 Free Blood Pressure test per beneficiary per Annum • 1 Free HIV Test per beneficiary per Annum • 1 Free HPV vaccination per beneficiary between 9 and 12 years of age • 1 Free Pneumococcal Vaccine per beneficiary above 65 Years of age per Annum • 1 Free Bone density per annum: Women from 50 years up to 69 years of age. Males at 65 years of age	Wellness Consultation: Subject to a family limit of R1 219per annum Preventative Care Screening: Family benefit of up to one (1) test per beneficiary per annum Subject to a family limit of R2 449per annum Include the following tests: Blood sugar, Cholesterol, Blood pressure, Body Mass Index, HIV screening test. One (1) screening test per beneficiary per annum. One (1) consultation visit in doctors' rooms. Limited to R310 per beneficiary per annum at a Preferred Provider facility. Females: Mammogram every 2 years for women above age 40 years, Pap smear every 2 years for women above 21 years. Males above 40 years: Prostate Specific Antigen (PSA) test Immunization/Vaccination: Flu Vaccine Pneumococcal Vaccine Human Papilloma Virus (HPV) vaccine Child Immunisation for children six (6) years and younger, immunization permitted will be in line with those provided by the Department of Health, subject to family wellness screening family limit

PREVENTATIVE CARE BENEFITS

	Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
9. Preventative Care Benefits				
9.1. Preventative Care Screening	100% of Scheme Tariff* • Wellness consultations: R1 219 per annum • Free COVID-19 Vaccination per beneficiary • Diabetic Eye Care • 1 Free Pap Smear for Females over 18 Years per beneficiary per Annum • 1 Free Mammogram for Females over 40 Years per beneficiary per Annum • 1 Free PSA for Males over 40 Years per beneficiary per Annum • 1 Free Cholesterol Test over 20 Years per beneficiary per Annum • 1 Free Flu Vaccine per beneficiary per Annum • 1 Free Blood Sugar Test over 15 Years per beneficiary per Annum • 1 Free Colon Cancer Blood Test over 50 years per beneficiary per Annum • 1 Free Blood Pressure test per beneficiary per Annum • 1 Free HIV Test per beneficiary per Annum • 1 Free HPV vaccination per beneficiary between 9 and 12 years of age • 1 Free Pneumococcal Vaccine per beneficiary above 65 Years of age per Annum • 1 Free Bone density per annum: Women from 50 years up to 69 years of age. Males at 65 years of age	100% of Scheme Tariff*. Paid from Risk • Wellness consultation: R1 781 • Free COVID-19 Vaccination per beneficiary • Diabetic Eye Care • 1 Free Pap Smear for Females over 18 Years per beneficiary per Annum • 1 Free Mammogram for Females over 40 Years per beneficiary per Annum • 1 Free PSA for Males over 40 Years per beneficiary per Annum • 1 Free Cholesterol Test over 20 Years per beneficiary per Annum • 1 Free Flu Vaccine per beneficiary per Annum • 1 Free Blood Sugar Test over 15 Years per beneficiary per Annum • 1 Free Colon Cancer Blood Test over 50 years per beneficiary per Annum • 1 Free Blood Pressure test per beneficiary per Annum • 1 Free HIV Test per beneficiary per Annum • 1 Free HPV vaccination per beneficiary between 9 and 12 years of age • 1 Free Bone density per annum: Women from 50 years up to 69 years of age. Males at 65 years of age • 1 Free Pneumococcal Vaccine per beneficiary above 65 Years of age per Annum	100% of Scheme Tariff* Wellness consultation – R1 219 per annum. • Free COVID-19 Vaccination per beneficiary • Diabetic Eye Care • 1 Free Pap Smear for Females over 18 Years per beneficiary per Annum • 1 Free Mammogram for Females over 40 Years per beneficiary per Annum • 1 Free PSA for Males over 40 Years per beneficiary per Annum • 1 Free Cholesterol Test over 20 Years per beneficiary per Annum • 1 Free Flu Vaccine per beneficiary per Annum • 1 Free Blood Sugar Test over 15 Years per beneficiary per Annum • 1 Free Colon Cancer Blood Test over 50 years per beneficiary per Annum • 1 Free Blood Pressure test per beneficiary per Annum • 1 Free HIV Test per beneficiary per Annum • 1 Free HPV vaccination per beneficiary between 9 and 12 years of age • 1 Free Pneumococcal Vaccine per beneficiary above 65 Years of age per Annum • 1 Free Bone density per Annum: Women from 50 years up to 69 years of age. Males at 65 years of age	Wellness consultation – R1 781 per family per annum • Free COVID-19 Vaccination per beneficiary • Diabetic Eye Care • 1 Free Pap Smear for Females over 18 Years per beneficiary per Annum • 1 Free Mammogram for Females over 40 Years per beneficiary per Annum • 1 Free PSA for Males over 40 Years per beneficiary per Annum • 1 Free Cholesterol Test over 20 Years per beneficiary per Annum • 1 Free Flu Vaccine per beneficiary per Annum • 1 Free Blood Sugar Test over 15 Years per beneficiary per Annum • 1 Free Colon Cancer Blood Test over 50 years per beneficiary per Annum • 1 Free Blood Pressure test per beneficiary per Annum • 1 Free HIV Test per beneficiary per Annum • 1 Free HPV vaccination per beneficiary between 9 and 12 years of age • 1 Free Pneumococcal Vaccine per beneficiary above 65 Years of age per Annum • 1 Free Pneumococcal Vaccine per beneficiary above 65 Years of age per Annum

PREVENTATIVE CARE BENEFITS

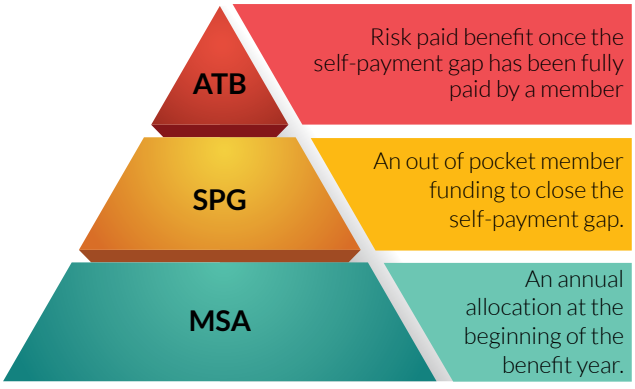
	Essential Copper	Silver Hospital	Access Saver 15 and 25	Gold Ascend and Gold Ascend EDO
9. Preventative Care Benefits				
9.2. HIV/AIDS Management Programme Unlimited Benefits subject to PMB's and registration on the Scheme's programme	100% of Scheme Tariff* Treatment is subject to the treatment care plan and clinical protocols per CDL	100% Negotiated Tariff*	100% of Scheme Tariff* Treatment is subject to the treatment care plan and clinical protocols per CDL	100% of Scheme Tariff HIV/AIDS is a PMB benefit and is subject to a Disease Management Program that infected beneficiaries are encouraged to enrol for
9.3. Chronic Disease Management Programme (CDL) Unlimited Benefits subject to registration on the Scheme's programme	100% of Scheme Tariff* Treatment is subject to the treatment Care plan and clinical protocols per CDL		100% of Scheme Tariff* Treatment is subject to the treatment Care plan and clinical protocols per CDL	100% of Scheme Tariff* Benefits are limited to PMB chronic conditions, subject to pre-authorisation, registration on the chronic disease programme, formulary and clinical protocols
9.4. COVID-19 Screening diagnosis and treatment. Subject to PMBs	100% of Scheme Tariff* Subject to PMB	100% Scheme Tariff	100% of Scheme Tariff*	COVID-19 Vaccine as approved by SAHPRA Pathology- COVID-19 test as approved by CMS In-Hospital treatment for COVID-19 pneumonia

PREVENTATIVE CARE BENEFITS

9. Preventative Care Benefits	Value and Value Core	Platinum Enhanced and Platinum Enhanced EDO	Plus	Titanium Executive
9.2. HIV/AIDS Management Programme Unlimited Benefits subject to PMB's and registration on the Scheme's programme	100% of Scheme Tariff* Treatment is subject to the treatment Care plan and clinical protocols per CDL	100% of Scheme Tariff HIV/AIDS is a PMB benefit and is subject to a Disease Management Program that infected beneficiaries are encouraged to enrol for	100% of Scheme Tariff* Treatment is subject to the treatment Care plan and clinical protocols per CDL	100% of Scheme Tariff* Treatment is subject to the treatment Care plan and clinical protocols per CDL
9.3. Chronic Disease Management Programme (CDL) Unlimited Benefits subject to registration on the Scheme's programme	100% of Scheme Tariff* Treatment is subject to the treatment Care plan and clinical protocols per CDL	100% of Scheme Tariff* Medical emergencies, Chronic conditions as listed in the Chronic Disease List (CDL), and medical conditions listed in the Diagnosis Treatment Pairs (DTPs)	100% of Scheme Tariff* Treatment is subject to the treatment Care plan and clinical protocols per CDL	100% of Scheme Tariff* Medical emergencies, Chronic conditions as listed in the Chronic Disease List (CDL), and medical conditions listed in the Diagnosis Treatment Pairs (DTPs)
9.4. COVID-19 Screening diagnosis and treatment. Subject to PMBs	100% of Scheme Tariff*	COVID-19 Vaccine as approved by SAHPRA Pathology- COVID-19 test as approved by CMS In-Hospital treatment for COVID-19 pneumonia	100% of Scheme Tariff* Subject to PMBs	100% of Scheme Tariff* COVID-19 Vaccine as approved by SAHPRA Pathology- COVID-19 test as approved by CMS In-Hospital treatment for COVID-19 pneumonia

Titanium Executive

OUT OF HOSPITAL BENEFIT (DAY-TO-DAY)



Legend
- MSA – Medical Savings Account
- SPG – Self Payment Gap
- ATB – Above threshold Benefit

How it works?

	Medical Savings Account	Self-Payment Gap
	Main Member – R18 300	Main Member – R4 369
	Adult Dependent – R16 560	Adult Dependent – R3 621
	Child Dependent – R3 720	Child Dependent – R1 656

Above Threshold Benefits: Unlimited, except for following sublimits:

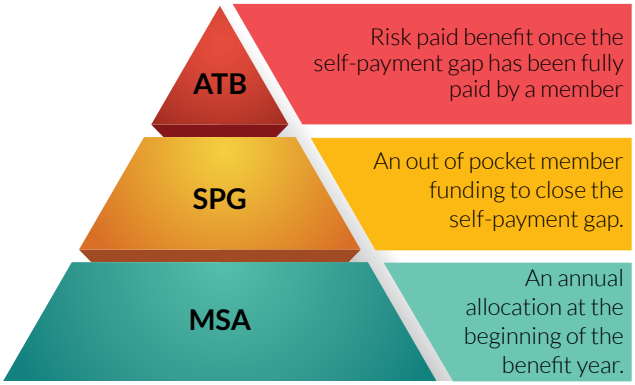
- Physiotherapy - limited to R15 000 per family per annum
- Pathology and radiology – limited to R15 000 per family per annum
- Acute Medicine:
  - R7 000 for main member
  - R7 000 for an adult dependent, and
  - R2 000 for a child dependent

Unused member savings accumulates year to year and is refundable should member resign a savings plan

Pt

Platinum Enhanced

ENHANCED OUT OF HOSPITAL BENEFIT (DAY-TO-DAY)



Legend
- MSA – Medical Savings Account
- SPG - Self Payment Gap
- ATB – Above threshold Benefit

How it works?

	Medical Savings Account	Self-Payment Gap
	Main Member – R11 160	Main Member – R1 895
	Adult Dependent – R10 680	Adult Dependent – R1 606
	Child Dependent – R2 820	Child Dependent – R414

Above Threshold Benefit (Sublimits)

- R5 568 for the main member
- R3 275 for an adult dependent, and
- R1 423 for a child dependent

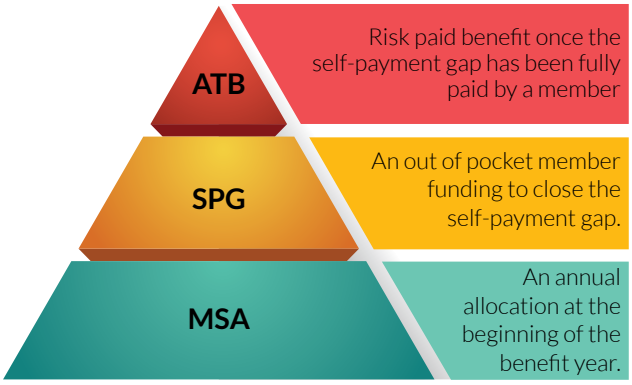
This includes cover for General Practitioners, Acute Medicines, X-rays , Blood Tests and other related out of hospital benefits

Unused member savings accumulates year to year and is refundable should member resign a savings plan

Pt EDO

Platinum Enhanced EDO

ENHANCED OUT OF HOSPITAL BENEFIT (DAY-TO-DAY)



Legend
- MSA – Medical Savings Account
- SPG - Self Payment Gap
- ATB – Above threshold Benefit

How it works?

	Medical Savings Account	Self-Payment Gap
	Main Member – R10 620	Main Member – R1 895
	Adult Dependent – R10 140	Adult Dependent – R1 606
	Child Dependent – R2 700	Child Dependent – R414

Above Threshold Benefit (Sublimits)

- R5 568 for the main member
- R3 275 for an adult dependent, and
- R1 423 for a child dependent

This includes cover for General Practitioners, Acute Medicines, X-rays , Blood Tests and other related out of hospital benefits

Unused member savings accumulates year to year and is refundable should member resign a savings plan

Annexure C - CHRONIC DISEASE LIST

The CDL list consists of the chronic conditions listed below:	
Addison's Disease	Epilepsy
Asthma	Glaucoma
Bipolar Mood Disorder	Haemophilia
Bronchiectasis	HIV/AIDS
Cardiac Failure	Hyperlipidaemia
Cardiomyopathy	Hypertension
Chronic Renal Disease	Hypothyroidism
Chronic Obstructive Pulmonary Disease	Multiple Sclerosis
Coronary Artery Disease	Parkinson's Disease
Crohn's Disease	Rheumatoid Arthritis
Diabetes Insipidus	Schizophrenia
Diabetes Mellitus Type I	Systemic Lupus Erythematosus
Diabetes Mellitus Type II	Ulcerative Colitis
Dysrhythmias	

OTHER CHRONIC DISEASE LIST (NON-CDL) 2023

Value Option & Value Core	Access Saver
Attention Deficit Hyperactivity Disorder (ADHD)	
Allergic Rhinitis	
Benign Prostatic Hypertrophy (BPH)	Benign Prostatic Hypertrophy (BPH)
Cushing's Disease	Cushing's Disease
Cystic Fibrosis	
Depression	
Endometriosis	Endometriosis
Gout	
Hyperthyroidism	Hyperthyroidism
Hypoparathyroidism	Hypoparathyroidism
Menopause / Hormone Replacement Therapy (HRT)	Menopause / Hormone Replacement Therapy (HRT)
Myasthenia gravis	Myasthenia gravis
Osteoarthritis	
Osteoporosis	
Paget's Disease	
Pituitary Microadenomas	
Psoriasis	
Stroke (Cerebrovascular accident)	Stroke (Cerebrovascular accident)

OTHER CHRONIC DISEASE LIST (NON-CDL) 2023

Titanium Executive

Platinum Enhanced

Platinum Enhanced EDO

Titanium Executive	Platinum Enhanced
Attention Deficit Hyperactivity Disorder (ADHD)	Attention Deficit Hyperactivity Disorder (ADHD)
Allergic Rhinitis	Allergic Rhinitis
Alzheimer's disease	
Anaemia: Vitamin B12 and Iron deficiency	Anaemia: Vitamin B12 and Iron deficiency
Aplastic anaemia	Aplastic anaemia
Ankylosing Spondylitis	
Anti-phospholipid syndrome	Anti-phospholipid syndrome
Benign Prostatic Hypertrophy (BPH)	Benign Prostatic Hypertrophy (BPH)
Chronic Urinary Tract Infection	
Cryoglobulinemia	
Cushing's Disease	Cushing's Disease
Cystic Fibrosis	Cystic Fibrosis
Delusional Disorders	
Depression	Depression
Dermatomyositis	
Endometriosis	Endometriosis
Enuresis	Endocarditis & Iron Deficiency Anaemia
Gastro-oesophageal reflux disease (GORD)	Gastro-oesophageal reflux disease (GORD)
Gout	Gout
Hyperthyroidism	Hyperthyroidism
Hypoparathyroidism	Hypoparathyroidism
Menopause / Hormone Replacement Therapy (HRT)	Menopause / Hormone Replacement Therapy (HRT)
Migraine	
Motor Neuron Disease	Motor Neuron Disease
Myasthenia gravis	Myasthenia gravis
Obsessive Compulsive Disorder	Obsessive Compulsive Disorder
Osteoarthritis	Osteoarthritis
Osteoporosis	Osteoporosis
Paget's Disease	Paget's Disease
Pancreatic Insufficiency	
Peripheral Vascular Disease	
Pituitary Microadenomas	Pituitary Microadenomas
Psoriasis	Psoriasis
Pulmonary Interstitial fibrosis	Pulmonary Interstitial fibrosis
Stroke (Cerebrovascular accident)	Stroke (Cerebrovascular accident)

OTHER CHRONIC DISEASE LIST (NON-CDL) 2023

Plus
Attention Deficit Hyperactivity Disorder (ADHD)
Allergic Rhinitis
Anaemia: Vitamin B12 and Iron deficiency
Aplastic anaemia
Anti-phospholipid syndrome
Benign Prostatic Hypertrophy (BPH)
Cushing's Disease
Cystic Fibrosis
Depression
Endometriosis
Gastro-oesophageal reflux disease (GORD)
Gout
Hyperthyroidism
Hypoparathyroidism
Menopause / Hormone Replacement Therapy (HRT)
Motor Neuron Disease
Myasthenia gravis
Obsessive Compulsive Disorder
Osteoarthritis
Osteoporosis
Paget's Disease
Pituitary Microadenomas
Psoriasis
Pulmonary Interstitial fibrosis
Stroke (Cerebrovascular accident)

DEFINITIONS:

Scheme rate*: As defined in Rule 4.9.68

"The tariff determined or adopted by the Board in respect of the payment for healthcare services rendered to Beneficiaries by service providers who are not subject to a DSP Tariff or a Negotiated Tariff, determined using the 2006 National Health Reference Price List (NHRPL) with the application of a year on year inflationary increase, as contemplated in Rule 15.11."

DSP*: As defined in Rule 4.9.28

"Designated Service Provider."

DSP Tariff*: As defined in Rule 4.9.29

"The fee determined in terms of an agreement between the Scheme and a service provider or a group of service providers in respect of the payment for the relevant health services."

Negotiated Tariff*: As defined in Rule 4.9.54

"A tariff negotiated and agreed ad hoc for services rendered between the Scheme and a healthcare service provider for services rendered by the relevant service provider to the Scheme or to Beneficiaries and which is different from the Scheme rate*."

Reference Price*: As defined in Rule 4.9.66

"The maximum reimbursable price for a list of generically similar or therapeutically equivalent products with a cost lower than that of the original medicine."

Formulary*: As defined in Rule 4.9.38

"A list of medicines that the Scheme will pay for the treatment of acute and chronic conditions as per the benefit option the member has selected."

Co-payment*: As defined in Rule 4.9.21

"A specified rand amount a beneficiary will be liable to self-fund for the cost of a specified medical treatment as stipulated in the benefits per option."

Deductible*: As defined in Rule 4.9.26

"A specific percentage or rand amount of the total hospital account related to a specific procedure as stipulated in the benefits per option that the beneficiary is liable for."

MSA*: As defined in Rule 4.9.51

"Medical Savings Account - that part of a Member's Contribution which remains an asset, where applicable, of the Member, but is held by the Scheme for his/her and his/her Dependants' exclusive benefit and use in accordance with the relevant Benefit Option and which funds are administered and regulated in terms of the Act and the Rules."

ICON*: Independent Clinical Oncology Network

Voluntarily*: Of one's own free will.

PMB*: "A set of defined benefits to ensure that all medical schemes members have access to certain minimum health services, regardless of the option they have selected".

EXCLUSIONS AND LIMITATIONS OF BENEFITS 2023

1. PRESCRIBED MINIMUM BENEFITS

The Scheme will pay in full, without co-payment or use of deductibles, the diagnosis, treatment, and care costs of the prescribed minimum benefits as per Regulation 8 of the Act. Furthermore, where a protocol or a formulary drug preferred by the scheme has been ineffective or would cause harm to a beneficiary, the scheme will fund the cost of the appropriate substitution treatment without a penalty to the beneficiary as required by regulation 15H and 15I of the Act.

2. LIMITATIONS AND RESTRICTIONS OF BENEFITS

2.1. The Scheme may require a second opinion in respect of proposed treatment or medication which may result in a claim for benefits and for that purpose the relevant beneficiary shall consult a dental or medical practitioner nominated by the Scheme and at the cost of the Scheme. The procedure to be followed in obtaining a second opinion is outlined in the relevant Scheme protocol (Protocol Regarding Requests for Second Opinions).

2.2. In cases where a specialist is consulted without the recommendation of a general practitioner, the benefit allowed by the Scheme may, at its discretion, be limited to the amount that would have been paid to the general practitioner for the same service.

2.3. Unless otherwise decided by the Scheme, benefits in respect of medicines obtained on a prescription are limited to one month's supply (or to the nearest unbroken pack) for every such prescription or repeat thereof.

2.4. If the Scheme or its managed healthcare organisation has evidence-based funding guidelines or protocols in respect of covered services and supplies, beneficiaries will only qualify for benefits in respect of those services and supplies with reference to the available funding guidelines and protocols irrespective of clinical guidelines that are not consistent with the scheme protocols and benefits.

2.5. The Scheme reserves the right not to pay for any new technology. Coverage of new technology will be assessed by the Scheme with due consideration given to:

2.5.1. medical necessity;

2.5.2. clinical evidence of its use in clinical medicine including outcome studies;

2.5.3. its cost-effectiveness;

2.5.4. its affordability;

2.5.5. its value relative to existing services or supplies;

2.5.6. its safety.

New technology is defined as any clinical intervention of a novel nature as well as those that the Scheme has not had previous experience with.

2.6. A 10% co-payment will be applied on the following procedure codes:

2.6.1. 1034 – Autogenous nasal bone transplant: Bone removal included.

2.6.2. 1035 – Functional endoscopic sinus surgery: Unilateral.

2.6.3. 1036 – Functional endoscopic sinus surgery: Bilateral.

2.6.4. 1087 – Sub-total reconstruction consisting of any two of the following:

2.6.4.1. Septum plasty, nasal osteotomy, nasal tip reconstruction.

2.6.5. 1085 – Total reconstruction of the nose:

2.6.5.1. including reconstruction of nasal septum (septum plasty), nasal pyramid (osteotomy), and nasal tip.

2.7. Mirena device Fund according to scheme protocol:

2.7.1. Not covered if used for contraception. Cover for abnormal uterine bleeding.

2.7.2. Insertion in rooms no co-payment applicable.

2.7.3. Insertion in theatre – co-payment R800.00, even if done in conjunction with another procedure.

2.7.4. Mirena device – cost from acute medicine benefit on Plus, Value, and Value Core Option only. Subject to payment from MSA for non-PMB on Access and subject to PMB on Essential Option.

2.8. The Scheme reserves the right to impose and apply exclusions and limits to the benefits that will be paid for medicines/procedures/interventions which have been accepted into the practice of clinical medicine through a process of health technology assessment/evaluation.

2.9. Benefits in respect of the cost of emergency medical treatment, as defined in the Medical Schemes Act, whilst abroad, are covered at the applicable Scheme rate* rates and RSA currency; Limited to the benefit entitlement and PMB protocols that would have applied in South Africa.

2.10. Optical Benefits payable as per managed care protocols.

2.11. Back and Neck surgery is subject to completion of conservative treatment.

2.12. Da Vinci Robotic Prostatectomy will only be funded for PMBs, subject to managed care protocols and pre-authorisation. Qualifying beneficiaries will be funded to the PMB level of care.

3. BENEFITS EXCLUDED

General exclusions mentioned in this paragraph are not affected by any specific exclusion. Unless otherwise decided by the Scheme (and 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:

3.1. All costs that exceed the annual or biennial maximum allowed for the particular category as set out in Annexure A, for the benefits to which the member is entitled in terms of the rules.

3.2. All costs for operations, medicines, treatments and procedures for cosmetic purposes or for personal reasons.

3.3. If, in the opinion of the medical advisor, the healthcare service in respect of which a claim is made, is not appropriate and necessary for any aspect of the management of the medical condition at an affordable level of service and cost.

3.4. All costs for treatment, if the efficacy and safety of such treatment cannot be proved.

3.5. All costs for services rendered by:

3.5.1. persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or

3.5.2. any institution, nursing home or similar institution, except a state or provincial hospital, not registered in terms of any law.

3.6. Abdominoplasties (including the repair of divarication of the abdominal muscles).

3.7. Accommodation and services provided in a geriatric hospital, old age home, frail care facility or the like (unless specifically provided for in Annexure A).

3.8. Art therapist, aromatherapist, massage therapist, reflexologist, Chinese medicine practitioners, acupuncturist.

3.9. Anabolic steroids, immunostimulants (except for immunoglobulins and growth hormones, which are subject to pre-authorisation by the relevant managed healthcare programme).

3.10. Ante- and postnatal exercises.

3.11. Appointments which a beneficiary fails to keep.

3.12. Appliances, devices and procedures not scientifically proven or appropriate.

3.13. Arch supports including shoe inserts.

3.14. Aromatherapy.

3.15. Autopsies.

3.16. Ayurvedics.

3.17. Back rests and chair seats.

3.18. Bandages and dressings (except medicated dressings subject to authorisation by the relevant managed healthcare programme).

3.19. Beds and mattresses.

3.20. Surgery for gynaecomastia, unless PMB.

3.21. Blepharoplasties; Unless there is documented evidence of visual impairment where the eyelid has covered or has encroached upon the pupil. Where this applies, benefits are limited to the affected eye only.

3.22. Breast augmentation.

3.23. Breast reconstruction (unless necessitated by pre-authorised surgical mastectomy, traumatic mastectomy or congenital unilateral absence of a breast which is subject to Scheme protocol).

3.24. Breast reductions and breast augmentations.

3.25. Any nasal surgery done by a plastic surgeon unless it is related to a pathological condition or PMB diagnosis.

3.26. Coloured or cosmetic effect contact lenses, and contact lens accessories and solutions.

3.27. Contraception, (excluding tubal ligation, vasectomy, oral contraception and injectable), IUDs for contraceptive purposes and contraceptive foams.

3.28. Cosmetic preparations, emollients, moisturisers, medicated or otherwise, soaps, scrubs and other cleansers, sunscreen and sun tanning preparations, medicated shampoos and conditioners, not including coal tar products and the treatment of lice infestation, scabies and other microbial infections (subject to PMB regulations).

3.29. Dental procedures or devices which are not regarded by the relevant managed healthcare programme as clinically essential or clinically desirable; and costs for:

3.29.1. anaesthetics in respect of dental services:

general anaesthetics for dental work except in the case of patients under the age of 7 years and symptomatic bony impaction of third molars and exposures that form part of an Orthodontic treatment plan; conscious sedation is limited to children below 12 years;

3.29.2. Orthodontic treatment over the age of 21 years; orthodontic plans that continue past the beneficiaries 21st birthday will only be paid up to their 21st birthday, the remainder of the treatment plan will be rejected and member may be liable;

3.29.3. Periodontal surgery for cosmetic reasons ,

3.29.4. use of high impact acrylic and precious metal in dentures or the cost of precious metal as an alternative to semi-precious or non-precious metal in dental prosthesis; and

3.29.5. genioplasty and dental osteotomy.

3.30. Oral hygiene instructions.

3.31. Fluoride application for beneficiaries above the age of 12 years.

3.32. Dental implants, components and surgery associated with dental implants on Access and Essential options.

3.33. Hospital admissions in adults based on fear and anxiety alone.

3.34. Multiple admissions for extensive (three (3) or more teeth requiring treatment) conservative dental treatment in children seven (7) years and younger (one (1) admission every 24 months allowed).

3.35. In-hospital Apisectomies, dentectomies.

3.36. Soft base to new dentures.

3.37. Diagnostic dentures.

3.38. Provisional crowns.

3.39. Laboratory cost of provisional and emergency crowns.

3.40. Metal, porcelain or Resin inlays except where such inlays form part of a bridge.

3.41. Dental bleaching and porcelain veneers.

3.42. Resin bonding for restorations charged as a separate procedure.

3.43. Crowns &bridge work, 4-surface fillings and root canal treatment on non-functional third molars (wisdom teeth) and Pontics on second molars.

3.44. Fixed prosthodontics used to repair occlusal wear.

3.45. Periodontal flap surgery and tissue grafting; perio-chip.

3.46. Gingivectomy.

3.47. Metal base to full dentures, including the laboratory cost.

3.48. Lingual orthodontics and Orthodontic re-treatment.

3.49. Orthognathic (jaw correction) surgery and the related hospital cost.

3.50. Bone augmentations including materials and sinus lift procedures.

3.51. Bone and other tissue regeneration procedures including material cost.

3.52. Mouth guards, Snoring appliances, high impact acrylic, cost of Mineral Trioxide, cost of prescribed toothpastes, mouthwashes (e.g. Corsodyl), and ointments.

3.53. Cost of gold, precious metal, semi-precious metal and platinum foil, and invisible retainer material.

3.54. Nutritional and tobacco counselling.

3.55. Caries susceptibility and microbiological tests.

3.56. Electrognathographic recordings and other such electronic analyses.

3.57. Ozone therapy.

3.58. Polishing of restorations.

3.59. Pulp capping (direct and indirect).

3.60. Root canal treatment and laboratory fabricated crowns on primary teeth.

3.61. Fissure sealants on patients older than 16 years.

3.62. Diagnostic kits, agents, and appliances – unless otherwise stated – except for diabetic accessories (subject to PMB regulations and Scheme protocols).

3.63. Treatment of depression using sleep therapy.

3.64. Electric tooth brushes.

3.65. Treatment for erectile dysfunction and loss of libido.

3.66. Patented food and nutritional supplements – including baby food and special milk preparations – unless 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 disease management programme.

3.67. Gender re-assignment treatment.

3.68. Genioplasties.

3.69. Headaches: oral appliances and the ligation of temporal artery and its branches for the treatment of headaches.

3.70. Hirsutism.

3.71. Holidays for recuperative purposes.

3.72. Humidifiers, without clinical indication.

3.73. Medical and surgical treatment, which is not included in the Prescribed Minimum Benefits in the Regulations to the Medical Schemes Act 131 of1998, Annexure A, Paragraph 9, Code 902M (as amended):

- Assisted Reproductive Technology (ART).
- In-vitro fertilization (IVF).
- Gamete Intrafallopian tube transfer (GIFT).
- Zygote Intrafallopian tube transfer (ZIFT).
- Intracytoplasmic sperm injection (ICSI).

3.74. Vasovasostomy (reversal of vasectomy), and Salpingostomy for reversal of tubal ligation.
3.75. Ionizers and air purifiers.
3.76. Iridology.
3.77. Surrogate pregnancy; including all services.
3.78. Keloid surgery, except for burns and functional impairment deemed by the Scheme to medically necessary.
3.79. Laxatives, subject to Scheme protocols.
3.80. Medical, surgical and orthopaedic appliances, devices and products, including oxygen hire or purchase and attachments, subject to PMB regulations and Scheme protocols.
3.81. Medication in respect of substance abuse treatment unless specifically authorised by the relevant managed healthcare programme, subject to PMB regulations.
3.82. 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).
3.83. Medicine not approved by the Medicines Control Council or other statutory body empowered to approve/register medications.
3.84. homeopathic medication on the Value, Value Core, Access and Essential Option.
3.85. MRI scans ordered by a general practitioner, subject to Scheme protocols.
3.86. Obesity treatment.
3.87. Optical devices excluded by the relevant managed healthcare programme.
3.88. Orthopaedic shoes and boots, subject to Scheme protocols.
3.89. Osteopathy.
3.90. Otoplasties.
3.91. Pain relieving machines, e.g. TENS, APS.
3.92. Medicines, household remedies and propriety preparations and preparations not otherwise classified,
3.93. Positron Emission Tomography (PET) scans where applicable; subject to ICON protocols and oncology registration.
3.94. Refractive surgery.
3.95. Excimer laser treatment.
3.96. Reflexology.
3.97. Revision of scars; except following burns and for functional impairment.
3.98. Rhinoplasties.
3.99. Smoking cessation and anti-smoking preparations.
3.100. Stethoscopes.
3.101. Sunglasses and repairs to spectacle frames.
3.102. Consultation and treatment by registered councillors, subject to prescribed minimum benefits.
3.103. Tonics, evening primrose oil, fish liver oils, nutritional supplements, multivitamin preparations, and minerals (except prenatal vitamins) as approved by the Scheme's pharmacy benefit management programme.
3.104. Topical preparations excluding topical steroid and acne preparations.
3.105. Travelling expenses.
3.106. Uvulo-palatal pharyngoplasty (UPPP and LAUP).
3.107. Veterinary products.
3.108. Pharmacy service fees.
3.109. Fentonplasty.
3.110. Insulin pumps (except for children seven (7) years or younger with frequent documented events of hypo- and hyperglycaemia). Exclusion applicable to Access and Essential option only.
3.111. Green laser prostatectomy.
3.112. Healthcare services obtained during general and/or condition specific waiting period, imposed upon joining the Scheme.
3.113. All claims where ICD-10 codes are missing, invalid or incomplete will be rejected.
3.114. Booking fees and birthing fees charged by providers for non-medical reasons.
3.115. Fees or levies imposed by healthcare practitioners as part of their administration costs.
3.116. Costs of diagnostic tests done in hospital which are not related to the reason for admission or for which admission is not clinically appropriate.
3.117. Allergy screening panels and/or desensitisation.
3.118. Where the provider of service refuses to provide adequate clinical motivation or supporting evidence of diagnosis the scheme reserves the right to decline funding.
3.119. Laparoscopic oesophagogastric fundoplasty (e.g. Nissen, Toupet procedures), except hernia repair and other PMB levels of care;. Organs and haemopoietic stem cell (bone marrow) donations; and immunosuppressive medication to any person other than to a Hosmed beneficiary.
3.120. The following exclusions apply for emergency medical services: Social transfers, patient pick up from home to dialysis treatment; and Acute admissions to step-down facilities.

The member, therefore, acknowledges 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 or his claim.

ANNEXURE E

PRESCRIBED MINIMUM BENEFITS

1. Designated service providers (DSP)

A healthcare provider or group of providers selected by the Scheme as preferred provider(s) to provide to the Beneficiaries, diagnosis, treatment, and care in respect of one or more Prescribed Minimum Benefit conditions.

The service provider(s) designated by the Scheme for the delivery of Prescribed Minimum Benefits to its Beneficiaries are those providers in respect of whom the Scheme has entered into an agreement. Beneficiaries can obtain information – including whether a service provider is a DSP – by communicating and requesting such information from the Scheme.

2. Prescribed minimum benefits obtained from DSPs

100% of the cost in respect of diagnosis, treatment, and care costs of Prescribed Minimum Benefit conditions if those services are obtained from a DSP.

3. Prescribed Minimum Benefits voluntarily obtained from other providers

If a Beneficiary voluntarily obtains diagnosis, treatment, and care in respect of a Prescribed Minimum Benefit condition from a provider other than a DSP, the benefit payable in respect of such service shall be the Scheme rate*.

4. Prescribed Minimum Benefits involuntarily obtained from other providers

(a) If a Beneficiary involuntarily obtains diagnosis, treatment ,and care in respect of a Prescribed Minimum Benefit condition from a provider other than a DSP, the Scheme will pay 100% of the cost in relation to that Prescribed Minimum Benefit conditions.

(b) For the purposes of paragraph 4(a) above, a Beneficiary will be deemed to have involuntarily obtained a service from a provider, other than a DSP, if:

(i) the service was not available from the DSP or would not be provided without unreasonable delay;

(ii) immediate medical or surgical treatment for a Prescribed Minimum Benefit condition was required under circumstances or at locations which reasonably precluded the Beneficiary from obtaining such treatment from a DSP; or

(iii) there was no DSP within reasonable proximity to the Beneficiary's ordinary place of business or personal residence.

(c) Except in the case of an emergency medical condition, pre-authorisation shall be obtained by a Member prior to involuntarily obtaining a service from a provider other than a DSP in terms of this paragraph, to enable the Scheme to confirm that the circumstances contemplated in paragraph 4(b) above are applicable.

(d) Where pre-authorisation has not been obtained by the Member in accordance with paragraph 4(c) above, the benefit payable in respect of such service shall be the Scheme rate*.

5. Medication

(a) Where a Prescribed Minimum Benefit includes medication, the Scheme will pay 100% of the cost of that medication if that medication is obtained from a DSP, or is involuntarily obtained from a provider other than a DSP, and

(i) the medication is included on the applicable formulary in use by the Scheme; or

(ii) the formulary does not include a drug that is clinically appropriate and effective for the treatment of that Prescribed Minimum Benefit condition.

(b) Where a Prescribed Minimum Benefit includes medication, a co-payment of 30% of the cost of the medicine and its supply will apply if:

(i) that medication is voluntarily obtained from a provider other than a DSP; and/or

(ii) the formulary includes a drug that is clinically appropriate and effective for the treatment of a Prescribed Minimum Benefit condition suffered by a Beneficiary, and that Beneficiary knowingly declines the formulary drug and opts to use another drug instead. In the event of 5(b) (i) and 5(b) (ii) being applicable, the cumulative co-payment which becomes payable will be 30%.

6. Prescribed Minimum Benefits obtained from a public hospital

Notwithstanding anything to the contrary contained in these Rules, the Scheme shall pay 100% of the costs of Prescribed Minimum Benefits obtained in a public hospital, without limitation.

7. Diagnosis tests for an unconfirmed Prescribed Minimum Benefit Diagnosis

Where diagnostic tests and examinations are performed but do not result in confirmation of a Prescribed Minimum Benefit diagnosis, except for an emergency medical condition, such diagnostic tests or examinations are not considered to be a Prescribed Minimum Benefit.

8. Payment of Prescribed Minimum Benefit Claims

In line with the Council's various circulars, and in particular Circular 13 of 2012 as well as the outcome of the court case between the Registrar and the Board of Healthcare Funders, the Scheme pays PMB's at cost and as per the rates. On initial submission of the claim, the claim is paid up to 200% of the Scheme's tariff and then the balance is investigated, analysed, verified, and adjudicated and – where applicable – paid following an enquiry by a member or service provider.

9. Co-payments

Co-payments in respect of the costs for Prescribed Minimum Benefit's may not be paid out of Medical Savings Accounts.

10. Chronic conditions

Any Benefit Option covers the full cost for services rendered in respect of the Prescribed Minimum Benefits, which includes the diagnosis, medical management, and medication to the extent that it is provided for in terms of a therapeutic algorithm as prescribed for the specified chronic conditions.

The list of chronic conditions which are Prescribed Minimum Benefits include:

(1) Addison's disease
(2) Asthma
(3) Bi-polar mood disorder
(4) Bronchiectasis
(5) Cardiac failure
(6) Cardiomyopathy disease
(7) Chronic renal disease
(8) Coronary artery disease
(9) COVID-19
(10) Chronic obstructive pulmonary disorder
(11) Crohn's disease
(12) Diabetes insipidus
(13) Diabetes mellitus type 1
(14) Diabetes mellitus type 2
(15) Dysrhythmias
(16) Epilepsy
(17) Glaucoma
(18) Haemophilia
(19) HIV/AIDS
(20) Hyperlipidaemia
(21) Hypertension
(22) Hypothyroidism
(23) Multiple sclerosis
(24) Parkinson's disease
(25) Schizophrenia
(26) Ulcerative colitis
(27) Rheumatoid arthritis
(28) Systemic lupus erythematosus

ANNEXURE F

MEDICAL SAVINGS ACCOUNT
Access Option

1. On admission to the Scheme, a Medical Savings Account (MSA) shall be established in the name of the new Member.

2. A MSA shall generally be credited with:
a. that part of the contributions received form the Member as specified in paragraph 4 below; and
b. the interest and any other return on investment as specified in paragraph 5 below.

3. A MSA shall generally be debited with:
a. the healthcare benefits utilised by the Member and his/her Dependants as specified in paragraphs 6 and 7 below; and
b. any debt owed by the Member to the Scheme as contemplated by Rule 13.5 and paragraph 9 below.

4. The Scheme shall not allocate more than 20% of the gross contributions received from a Member during a financial year to his/her MSA.

5. The sum of Member's MSA funds may attract returns on such investments (be it in the form of interest), which returns shall be credited by the Scheme to each Member's accumulated positive balance.

6. The MSA will form part of the Scheme overall assets.

7. During the term of a Member's membership of the Scheme, the Member's MSA funds (including, but not limited to, the investment returns specified in paragraph 5 above) shall be available for the exclusive benefit and use of the Member and his/her Dependants as specified in paragraph 8 below.

8. Subject to sufficient funds being available in a Member's MSA at the date on which a claim is processed, the Member and his/her Dependants shall be entitled to claim for healthcare services in accordance with the provisions of the Act, the Rules and their Benefit Option, and – in particular – at the agreed Rate as specified in Annexure A3 to the Rules.

9. Whilst being on a particular Benefit Option of the Scheme which provides for a MSA, the Scheme shall not be entitled to use the Member's MSA funds to pay for the cost of a prescribed minimum benefit or to offset any outstanding contributions, penalties or other debt due and payable to the Scheme.

10. However, on the death of a Member, or on the termination of a Member's membership of the Scheme, or on the transfer of a Member from a particular Benefit Option of the Scheme which provides for a MSA to any other of the Scheme's Benefit Options, the funds in the Member's MSA may be used to offset any debt owed by the Member to the Scheme, including (but not limited to) outstanding contributions, penalties and any claims which may be submitted to the Scheme for payment following the date of such death, termination or transfer.

11. Should a Member elect to transfer between two of the Scheme's Benefit Options which both provide for a MSA, or from one of the Scheme's Benefit Options to that of another medical Scheme which both provide for a MSA, any MSA balance due to the Member (subject to the adjustments specified in paragraphs 3, 7, 9, 11 and 12 above) shall be transferred by the Scheme to the Member's MSA on his/her new Benefit Option with the Scheme or to the other medical Scheme (as the case may be) within five (5) months of the date of such transfer between such two Scheme Benefit Options or of the date of termination of the Member's membership by the Scheme (as the case may be), subject to the applicable taxation laws.

12. Should a Member elect to transfer from one of the Scheme's Benefit Options which provide for a MSA to another of the Scheme's Benefit Options which does not so provide, any MSA balance due to the Member (subject to the adjustments specified in paragraphs 3, 7, 8, 10, and 11 above) shall be refunded by the Scheme to the Member.

13. Should a Member's membership be terminated for reasons other than his/her death and s/he not be admitted as a member of another medical Scheme or be admitted to a benefit option of another medical Scheme which does not provide for a MSA, any MSA balance due to the Member (subject to the adjustments specified in paragraphs 3, 7, 8, 10, and 11 above) shall be refunded by the Scheme to the Member within five (5) months of the date of termination of the Member's membership by the Scheme, subject to the applicable taxation laws.

14. Upon the death of a Member, any MSA balance due to the deceased Member (subject to the adjustments specified in paragraphs 3, 7, 8, 10, and 11 above) shall be transferred by the Scheme to the MSA of the Dependant of the deceased Member who is elected as the new Member in terms of Rule 6.4.1 and who continues membership of the Scheme or, in the absence of such a Dependant, shall be paid by the Scheme to the deceased Member's estate, subject to the applicable taxation laws.

15. If a Member (or his/her lawful heirs) become legally entitled to repayment of any MSA funds, and such a Member (or his/her lawful heirs) fail to claim such funds within three (3) years of becoming entitled thereto, then such funds shall be written back to the Scheme.

Claims in respect of benefits for conditions indicated as payable from the PMSA as per the benefits in the Scheme rules shall first be allocated against the member's PMSA and once these have been exhausted, offset against the accumulated funds.

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