ANNEXURE B1

COMPREHENSIVE OPTION

BENEFITS

Effective 1 January 2023

A ENTITLEMENT TO BENEFITS

Members and their registered dependants are entitled to benefits stipulated in paragraphs 1 to 25 (and paragraph 26) (unless excluded as provided for in Annexure C) subject to the following:

1. Prescribed Minimum Benefits

Notwithstanding anything to the contrary in this schedule, the Scheme will pay in full, without co-payment or use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefits obtained in South Africa 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. Also refer to Annexure E (Prescribed Minimum Benefits).

2. **General**

The payment of benefits shall be subject to -

2.1 The provisions of these rules.

2.2 The conditions stipulated in preamble B of this Annexure and the conditions in paragraph 1 of Annexure C.

2.3 For a member admitted during the course of a financial year the maximum benefits available to such member shall be adjusted in proportion to the period of membership from the admission date to the end of the financial year; provided further that there shall be no reduction in limits per case.

B CONDITIONS APPLICABLE

1 Where specifically indicated in this Annexure that a member's entitlement to benefits shall be subject to such healthcare management programme as may be stipulated in preamble C the member shall be obliged to furnish any information required by the Scheme to perform its duties. Specifically the Scheme may require particulars of diagnosis, clinical investigations, procedures and treatment by the attending medical practitioner of the beneficiary prior to admission of the beneficiary to hospital or on to the Disease Management/Case Management Programmes.

1.1 If the health problems of Beneficiaries are of such a nature that they qualify for admission to the Scheme's Case Management Programme and/or Disease Management, the Scheme may enter such Beneficiaries on such a programme either on request of a Beneficiary, or automatically.

1.2 If the Scheme uses a Case Management Programme and/or Disease Management, the Scheme may, at its sole discretion, grant amounts in excess of the Benefits specified and not subject to the exclusions in this annexure, if it falls within the treatment plan of the case management programme

1.3 If a Beneficiary refuses participation in a Case Management Programme and/or Disease Management, the Scheme may pay benefits for a lower level of service, subject to PMB regulations.

1.4 If a Beneficiary does not co-operate with the relevant Case Management Programme and/or Disease Management, the Scheme may impose a co-payment, subject to PMB regulations.

1.5 Admission on the Disease Management/Case Management programmes is subject to registration of the relevant management programme and will include contact by Disease/Case Managers or third party providers.

2 A request for pre-authorisation shall be made, except in case of an emergency, to the hospital benefit management programme before a beneficiary is admitted to a hospital or day clinic or before a beneficiary receives a relevant health service at such institution.

If authorisation is not obtained (except in the case of an emergency), or in case of failure to furnish such information or to grant permission for access to such information as may be required, the member may be required to make a co-payment in the amount of R500.

3 In the event of an emergency the Scheme shall be notified of such emergency within one working day after admission to hospital failing which the co-payment shall apply, but can be revisited subject to clinical motivation and PMB regulations.

C SCHEDULE OF HEALTH MANAGEMENT PROGRAMMES AND DESIGNATED SERVICE PROVIDERS

(a) Ambulance services management programme: preferred provider for the administration of the agreed ambulance services benefit structure stipulated in paragraph 3 of this Annexure

(b) Dentistry benefit management programme: preferred provider for the administration of the agreed dentistry benefit structure stipulated in paragraph 7 of this Annexure

(c) Extended or chronic medication programme: as defined

(d) Hospital benefit management programme: as defined

(e) Optical benefit management programme: Preferred provider for the administration of the agreed optical benefit structure stipulated in paragraph 14 of this Annexure

(f) Routine medication programme: as defined.

(g) Disease Management/Case Management Programmes including but not limited to HIV/AIDS Management Programme, Renal Disease Management Programme, Maternity Management Programme, Oncology Programme, Diabetes Management Programme, Alcohol and Drug Dependency: as defined.

(h) SABMAS Specialist Network: Preferred provider/Designated Service Provider: as defined. The Scheme designates the SABMAS Specialists Network as the Designated Service Provider for Specialist treatment in and out of hospital.

(i) SABMAS Preferred General Practitioner Network: a network of GP's whereby members can obtain healthcare services without incurring additional out of pocket costs. This is a voluntary network.

(ii) SABMAS Preferred Supplier of certain surgical items/devices including Joint replacements/prosthetics (excl. shoulder). The use of a provider outside this network, for these items, will result in claims accumulating to the applicable prosthesis limit.

Also refer to Annexure E (Prescribed Minimum Benefits).

MAJOR MEDICAL BENEFITS, CATEGORY LIMITS, DAY TO DAY BENEFITS AND SAVINGS

All limits depicted in this Annexure are annual limits, unless otherwise indicated.

Day to day benefits (depicted by a D in column 5) are subject to category limits as indicated and further subject cumulatively to the annual day to day benefit limits indicated in paragraph 26.2.

Major Medical Benefits (depicted by an M in column 5) are not subject to an Overall Annual Limit, but sub-limits may apply for certain benefit categories where indicated in this table.

Benefits that are subject to Savings are depicted by an S (see Annexure A1).

Continued benefits apply for Prescribed Minimum Benefits (PMBs) after depletion of limits, subject to PMB regulations and Annexure E.

	SERVICE	**% BENEFIT**	**ANNUAL LIMITS**		**CONDITIONS/REMARKS**
1.	**ALCOHOLISM AND DRUG DEPENDENCY**	100% of the lower of cost or recommended tariff for all services	21 days at a Sanca facility or at Sanca rates per beneficiary; PMB benefits subject to Annexure E	M	Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26 and the PMB regulations
2.	**ALTERNATIVE HEALTHCARE SERVICES** Treatment and medicines prescribed or supplied for: • Acupuncture • Naturopathy • Osteopathy	80% of the lower of cost or recommended tariff	Subject to Day-to-Day limit	D	Subject to the conditions and limits stipulated in paragraph 26 and PMB regulations
3.	**AMBULANCE SERVICES**	100% of the cost	Unlimited	M	Subject to the conditions and limits stipulated in paragraph 26, and PMB regulations

	• Transport of a beneficiary by a preferred provider • Transport of a beneficiary by any provider in the case of an emergency	100% of the lower of cost or recommended tariff	Unlimited	M	
4.	**APPLIANCES** Subject to the hospital benefit management programme, prior approval by the Scheme and the conditions and limits stipulated in paragraph 26				
4.1	Medical and surgical appliances, including hearing aids (Hearing aids only allowed once every three years)	100% of the cost	R19 435 per family	M	
4.1.1	Hearing aids (once every three years)	100% of the cost	Once every three years, included in medical and surgical appliances limit	M	
4.1.2	Hearing aid repairs (once every 2 years)	100% of the cost	R3 397 per beneficiary once every 2 years	M	
4.2	Home oxygen, cylinders, concentrators and ventilation expenses excluding CPAP machines	100% of the lower of cost or recommended tariff	Unlimited	M	Subject to Annexure E

5.	**BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS**	100% of the cost	Unlimited	M	Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26
6.	**CONSULTATIONS, VISITS AND PROCEDURES** This paragraph expressly excludes services provided in respect of dentistry (see paragraph 7), psychiatry (see paragraph 12.2), organ transplants (see paragraph 15), oncology (see paragraph 16) and renal dialysis (see paragraph 21) The Scheme designates the SABMAS Specialist Network as the Designated Service Provider for Specialist treatment in and out of hospital. These Service Providers shall for the purpose of this Annexure be referred to as Designated Service Providers (DSP's). The DSP will be responsible for the provision of all benefits including PMBs. The Scheme nominates the Preferred GP Network for the provision of such GP services as listed below.				
6.1	**In hospital:** Consultations and visits by general practitioners, medical specialists and nurse practitioners in hospital	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff	Unlimited	M	Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26 and PMB regulations
6.2	**Out of hospital:** Consultations and visits to general practitioners, medical specialists and nurse practitioners in the supplier's rooms or patient's home or primary health care facility	GP consultations: 100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff Medical specialist consultations: 80%	R5 370 per beneficiary for all services combined, including surgical procedures and consumables	D	Subject to the conditions and limits stipulated in paragraph 26 and PMB regulations

		of the negotiated fee where applicable or 80% of the lower of cost or recommended tariffs, where member is referred by a general practitioner. 60% of the negotiated fee where applicable or 60% of the lower of cost or recommended tariff where member is **not** referred by a general practitioner			

6.3	**Endoscopies**				
6.3.1	**In hospital:** • Colonoscopy • Gastroscopy • Colonoscopy + Gastroscopy • Sigmoidoscopy	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff	Unlimited Single endoscopy: Copayment R4 100 Multiple endoscopy: Copayment R5 150	M	Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26 and PMB regulations
6.3.2	**Out of hospital:** • Colonoscopy • Gastroscopy • Colonoscopy + Gastroscopy • Sigmoidoscopy	80% of the negotiated fee where applicable or 80% of the lower of cost or recommended tariffs	Subject to Day-to-Day limit Single endoscopy: Copayment R4 100 Multiple endoscopy: Copayment R5 150	D	Subject to the conditions and limits stipulated in paragraph 26 and PMB regulations

6.4	In-and out-of-hospital management for spinal care and surgery for defined clinically appropriate procedures	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff at a network facility.	Unlimited		Subject to authorisation and the treatment meeting the Scheme's treatment _guidelines and clinical criteria. Basket of care as set by the Scheme for out-of-hospital conservative treatment
		Network does not apply to any admissions related to trauma. 80% of the negotiated fee where applicable or 80% of the lower of cost or recommended tariff if performed at a non-network facility.			
6.5	**Readmissions Prevention Benefit**: For defined clinically appropriate conditions and risk categories	100% of the lower of cost or recommended tariff			Subject to the treatment meeting the Scheme's treatment guidelines and clinical criteria. Basket of care as set by the Scheme

6.6	**Pre-Advanced Illness support:** For defined clinically appropriate conditions and risk categories	100% of the lower of cost or recommended tariff	Unlimited, subject to Annexure E		Subject to the treatment meeting the Scheme's treatment guidelines and clinical criteria. Basket of care as set by the Scheme

7.	**DENTISTRY** Subject to the dentistry benefit management programme and the conditions and limits stipulated in paragraph 26				
7.1	**Basic dentistry**				
7.1.1	Dental practitioners: For basic dentistry (excluding surgical extractions), oral medical procedures, plastic dentures and cost of dental technicians fees for all such dentistry	80 % of the lower of the cost or recommended tariffs	Subject to Day-to-Day limit Upfront payment for Basic dentistry performed In Hospital / Day Clinic: 12 years and younger - R 2 650 In Hospital / R1 200 in Day Clinic 13 years and older - R6 800 in Hospital / R4 350 in Day Clinic	D	

7.1.2	Dental therapists: For basic dentistry performed by dental therapists	80% of the lower of cost or recommended tariff	Subject to Day-to-Day limit	D	
7.1.3	**Oral hygienist** For basic dentistry performed by oral hygienists.	80% of the lower of cost or recommended tariff.	Subject to day to day limit.	D	

7.2	**Advanced dentistry** For inlays, crowns, bridges, mounted study models, metal base dentures, the treatment by periodontists (excluding oral medical procedures) and prosthodontists and the cost of dental technicians' fees for all such dentistry	80% of the lower of cost or recommended tariff	M0 R12 129 M1+ R15 868	M M	

7.3	**Osseo-integrated implants & Orthognathic Surgery** For all services rendered including the cost of special investigations, hospitalisation, all general and specialist dental practitioners and their respective assistants and anaesthetist as well as the cost of materials including all implant components, plates, screws and bone and bone equivalents	100% of the lower of cost or recommended tariff	Subject to and included in Advanced Dentistry limit	M	Subject to the dentistry benefit management programme and the conditions and limits stipulated in paragraph 26
7.4	**Oral surgery** For consultations, visits, and surgical procedures by maxillo-facial specialists and dental practitioners	100 % of the lower of cost or recommended tariff	Unlimited	M	Subject to the hospital benefit management programme
7.5	**Maxillo-facial surgery**	100% of the lower of cost or recommended tariff	Unlimited	M	Subject to the hospital benefit management programme See paragraph 24 (Surgical Procedures)
7.6	**Orthodontic treatment**	80% of the lower of cost or recommended tariff	Subject to and included in Advanced Dentistry limit	M	Subject to prior approval by the Scheme

8.	**HOSPITALISATION**				
8.1	**Private and public hospitals, registered unattached operating theatres, day clinics, sub-acute facilities and hospice - in hospital** This paragraph expressly excludes the benefit for hospitalisation arising out of osseo-integrated implants and orthognathic surgery (see paragraph 7.3), mental illness (see paragraph 12.1), refractive surgery (see paragraph 14.5) and pregnancy/childbirth (see paragraph 19.1); PMB benefits are subject to Annexure E				
8.1.1	For accommodation in a general ward, high care ward and intensive care unit	100% of the lower of cost or recommended tariff	Unlimited	M	Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26
8.1.2	For theatre fees	100% of the lower of cost or recommended tariff	Unlimited	M	
8.1.3	For materials and hospital equipment and the transport of blood	100% of the lower of cost or recommended tariff	Unlimited	M	

8.1.4	Medicines	100% of the lower of cost or the price determined by the hospital benefit management programme plus the negotiated professional charge for medicines	Unlimited	M	
8.1	**Private and public hospitals, registered unattached operating theatres, day clinics, sub-acute facilities and hospice - in hospital – continued**				
8.1.5	Medicines for a patient to take home (TTOs)	See paragraph 11.1.1.	See paragraph 11.1.1	D	Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26
8.2	**Private and public hospitals – out of hospital** Subject to the conditions and limits stipulated in paragraph 26:				
8.2.1	For out-patient services and materials	100% of the lower of cost or recommended tariff	Unlimited	M	
8.2.2	For medicines given to a patient to take home see paragraph 11.1.1.	100% of the price as determined by the hospital benefits management	See paragraph 11.1.1.	D	

		programme plus the negotiated professional charge for medicines			
8.3	**Alternatives to hospitalisation: Step-down facility & private nursing** For all services rendered by private nursing/rehabilitation centres and/or step down facilities	100% of the lower of the cost or recommended tariff	Unlimited	M	Subject to the hospital benefit management programme, the disease management programme and the conditions and limits stipulated in paragraph 26
8.4	**Rehabilitation in a private hospital:** For accommodation, services, consumables and equipment.	100% of the lower of cost or recommended tariff or negotiated fee	R97 092 per family	M	Subject to the hospital benefit management programme, the disease management programme and the conditions and limits stipulated in paragraph 26 PMB benefits subject to Annexure E
8.5	**Compassionate Care Benefit for non-oncology patients (inpatient care and home nursing)**	100% of the negotiated fee where applicable or 100% of the lower of cost between the negotiated fees and recommended tariff	R69 412 per person per lifetime	M	PMB benefits subject to Annexure E

9.	**IMMUNE DEFICIENCY RELATED TO HIV -** Subject to the Aid for AIDS programme, the disease management programme, the routine medication programme, the extended or chronic medication programme and the conditions and limits stipulated in paragraph 26				
9.1	**Anti-retroviral medicines**	100% of the cost, plus a fixed dispensing fee per line item where applicable	Unlimited, subject to Annexure E	M	
9.2	**Related medicines**	100% of the cost of medicines as determined by the routine medication programme or the extended or chronic medication programme plus the negotiated professional charge		M	
9.3	**All other services related to HIV**	Subject to Annexure E	Subject to Annexure E	M	Benefits for all other services shall be subject to Annexure E. If the relevant beneficiary does not comply with the stipulated protocols of the Disease Management programme, the right to

					benefits will be subject to the Provisions of Regulation 8 to the Medical Schemes Act
10.	**INFERTILITY**	Subject to Annexure E	Subject to Annexure E	M	Subject to the hospital benefit management programme, benefits payable will be in respect of the medical and surgical management as outlined in Annexure A of the Regulations (Code 902m)
11.	**MEDICINES, DEVICES AND INJECTION MATERIAL** This paragraph expressly excludes medicines and devices in respect of alternative health care practitioners, (see paragraph 2), organ transplants (see paragraph 15) and oncology (see paragraph 16)				
11.1	**Acute sickness conditions** Subject to the routine medication programme and the conditions and limits stipulated in paragraph 26				
11.1.1	**Legally prescribed acute medicine, including TTOs** In respect of registered medicines including injection material, prescribed by a person legally entitled to prescribe	80% of the lower of cost or the price as determined by the routine medication programme plus the negotiated dispensing fee charged	Subject to Day-to-Day limit, and further limited to R2 546 per female beneficiary for contraceptives	D	This paragraph excludes prescriptions supplied for use in a hospital but includes, without the payment of a levy, all medicines given to a patient to take home

11.1.2	**Pharmacy advised therapy (PAT)**	100% of cost	Subject to available savings	S	No routine benefit, payable from available savings
11.2	**Chronic sickness conditions: Medicines other than anti-retroviral medicines** In respect of registered medicines and administrative devices prescribed by a person legally entitled to prescribe, where a member or dependant suffers from an extended or chronic sickness condition	100% of the cost determined by the extended or chronic medication programme plus the negotiated dispensing fee charged at a Scheme DSP	For 26 CDL PMB conditions (subject to Annexure E) plus 28 additional conditions listed in paragraph 26 Medicine Reference Pricing/ MMAP applies	M	Subject to the extended or chronic medication programme and the conditions and limits stipulated in paragraph 26 Extended chronic list is detailed in paragraph 26
	Blood glucose monitoring devices	Any beneficiary approved and registered on the Scheme's Chronic Illness Benefit for Diabetes is covered up to 100% of the Scheme Rate.	1 per beneficiary per year		The device must be approved by the Scheme, subject to the Scheme's protocols and clinical entry criteria.

11.3	**Immunisation and vaccines** For providing and administering vaccines or immunisation for polio, rubella, measles, tetanus, diphtheria, mumps, flu, meningitis, hepatitis, whooping cough and pneumonia as prescribed by a person legally entitled to do so	80% of the lower of the cost or the price as determined by the routine medication programme, plus the negotiated professional charge	Subject to Day-to-Day limit	D	Subject to day-to-day limit only where not covered as part of the SABMAS Wellness benefit (paragraph 25)
12.	**MENTAL HEALTH BENEFIT**				
12.1	**Hospitalisation - Private and public hospitals** Subject to the hospital benefit management programme (applicable in hospital), the disease management programme and the conditions and limits stipulated in paragraph 26 and PMB regulations				
12.1.1	For accommodation in a general ward	100% of the lower of cost or recommended tariff	100% of the lower of cost or negotiated tariff at network facility.	M	At an approved facility PMB benefits subject to Annexure E
12.1.2	For electro convulsive therapy (ECT) fees	100% of the lower of cost or recommended tariff			
12.1.3	For materials and hospital equipment	100% of the lower of cost or recommended tariff			

12.1.4	Registered medicines	100% of the cost as determined by the hospital benefits management programme plus the negotiated professional charge	80% of the lower of cost or negotiated tariff at a non-network facility. R45 179 per beneficiary		
12.	**MENTAL HEALTH BENEFIT - continued**				
12.2	**Consultations, visits and procedures** The Scheme designates the SABMAS Specialist Network as the Designated Service Provider for Specialist treatment in and out of hospital. These Service Providers shall for the purpose of this Annexure be referred to as Designated Service Providers (DSP's). The DSP will be responsible for the provision of all benefits including PMBs				
12.2.1	**In hospital**				
	For consultations and visits at an approved facility	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff	Unlimited	M	

	For procedures of general practitioners, psychiatrists, psychologists and social workers	100% of the lower of cost or recommended tariff	Unlimited	M	
12.2.2	**Out of hospital**				
	For consultations and visits at an approved facility	80% of the negotiated fee where applicable or 80% of the lower of cost or recommended tariff	R14 601 per family	M	
	For procedures of general practitioners, psychiatrists, psychologists and social workers at the supplier's rooms or in any facility or at any place other than a registered hospital	80% of the lower of cost or recommended tariff	PMB Benefits subject to Annexure E	M	
	Disease management for major depression for members registered on the Scheme's Disease Management Programme	100% of the lower of cost or recommended tariff	PMB Benefits subject to Annexure E		Subject to the treatment meeting the Scheme's treatment guidelines and managed care criteria. Basket of care as set by the Scheme

13.	**NON-SURGICAL PROCEDURES AND TESTS** This paragraph expressly excludes psychiatry (see paragraph 12.2) and eye examinations (see paragraph 14.4)				
13.1	In hospital: for all non-surgical procedures performed by a general practitioner or medical specialist	100% of the lower of cost or recommended tariff	Unlimited	M	Subject to the hospital benefit management programme (applicable in hospital), the disease management programme and the conditions and limits stipulated in paragraph 26
13.2	Out of hospital including practitioners' rooms: For all non-surgical procedures performed by a general practitioner or medical specialist	100% of the lower of cost or recommended tariff	Unlimited	M	
14.	**OPTICAL BENEFITS** Subject to the optical benefit management programme and the conditions and limits stipulated in paragraph 26				
14.1	**Frames and Readers**	Optometry consultation and optometry not otherwise specified. Up to a maximum of	R2 082 per beneficiary every 2 benefit years	D	Limited to one pair of frames per beneficiary every 2 benefit years Readers must be obtained from a registered optometrist

14.2	**Spectacle lenses** prescribed or supplied by a registered optometrist, ophthalmologist or supplementary optical practitioner	100% of the SAB Medical Scheme Rate. Subject to annual limits.	Subject to Day-to-Day limit	D	Limited to one pair of lenses per beneficiary per benefit year Scheme covers up to 35% of tinting and R316 per lens for lens hardening, limited to one pair of lenses per beneficiary per year
14.3	**Contact lenses and/or disposable contact lenses** (clinically essential, clear contact lenses)		R2 082 per beneficiary per annum (limit is combined with frames and readers limit)	D	Lenses must have been recommended by a registered optometrist, ophthalmologist or supplementary optical practitioner

14.4	**Eye examinations**	100% of the lower of cost or recommended tariff for eye examinations via a Preferred Provider Network Optometrist; or 80% of the lower of cost or recommended tariff if a non-network provider is used	Subject to Day-to-Day limit	D	Benefit not exceeding the composite fee for multiple procedures for eye examinations and tests performed by optometrists or ophthalmologists when clinically essential

14.5	**Refractive surgery**	100% of the negotiated fee where applicable or 100% of the lower of cost between the negotiated fees and recommended tariff	R10 778 per beneficiary per life time	M	Subject to clinical protocols and approval by the Medical Advisor One treatment per beneficiary per life time subject to pre-authorisation
15.	**ORGAN TRANSPLANTS** Subject to the approval by the Scheme prior to the work-up for surgery, the hospital benefit management programme, the disease management programme and the conditions and limits stipulated in paragraph 26 and the PMB regulations				
15.1	For consultations, visits, the harvesting of the organ and transplantation thereof	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff	Unlimited, subject to Annexure E	M	
15.2	For post- operative anti-rejection medicines	100% of the cost determined by the chronic medication programme plus the negotiated professional charge	Unlimited, subject to Annexure E	M	

16.	**ONCOLOGY** Subject to the hospital benefit management programme, the disease management programme and the conditions, benefit threshold limits and limits stipulated in paragraph 26 and the PMB regulations. A Benefit Threshold Limit equivalent to 80% of the Scheme rate becomes applicable after the Threshold Claim Amount has been reached. The Threshold Claim amount is R400 000 per beneficiary for a period of 12 months from the date of registration on the benefit.

16.1	For consultations, visits and for treatment and materials used in radiotherapy and chemotherapy	100% of the negotiated fee where applicable or 100% of the lower of cost between the negotiated fees and recommended tariff	Subject to Benefit Threshold Limit subject to Annexure E	M	
16.2	In respect of registered medicines used in radiotherapy and chemotherapy	100% of the cost determined by the hospital benefit management programme plus the negotiated professional charge	Subject to Benefit Threshold Limit, subject to Annexure E	M	

16.3	Advanced Illness Benefit for oncology patients	100% of the negotiated fee where applicable or 100% of the lower of cost between the negotiated fees and recommended tariff	Unlimited, subject to Annexure E		
16.4	Pre-AIB support programme	100% of the lower of cost or recommended tariff	Unlimited, subject to Annexure E		Subject to the treatment meeting the Scheme's treatment guidelines and managed care criteria. Basket of care as set by the Scheme
17.	**PATHOLOGY AND MEDICAL TECHNOLOGY** Subject to the hospital benefit management programme (applicable in hospital), the disease management programme and the conditions and limits stipulated in paragraph 26				
17.1	**In hospital:** For all tests performed by a pathologist or medical technologist	100% of the lower of cost or recommended tariff	Unlimited	M	
17.2	**Out of hospital:** For all tests performed by a pathologist or medical technologist	80% of the lower of cost or recommended tariff	Subject to Day-to-Day limit	D	

18.	**PHYSIOTHERAPY, BIOKINETICS AND CHIROPRACTORS** Subject to the hospital benefit management programme (applicable in hospital), the disease management programme and the conditions and limits stipulated in paragraph 26				
18.1	**In hospital:** For physiotherapy and biokinetics	100% of the lower of cost or recommended tariff	Unlimited	M	No benefit for chiropractors in hospital
18.2	**Out of hospital:** For physiotherapy, chiropractics (including x-rays) and biokinetics	80% of the lower of cost or recommended tariff	Subject to Day-to-Day limit	D	
19.	**PREGNANCY AND CHILDBIRTH** Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26				
19.1	**Hospitalisation (Public or private hospitals)**				
19.1.1	• For accommodation, theatre fees, labour ward fees, drugs, dressings and materials in a private or provincial hospital • For drugs, dressings, medicines and materials supplied by a midwife	100% of the lower of cost or recommended tariff 100% of the lower of cost or recommended tariff	Subject to the Maternity Programme	M	

19.1.2	In respect of registered medicines prescribed by a person legally entitled to prescribe or supplied by a midwife	100% of the cost as determined by the routine medication programme or the extended or chronic medication programme plus the negotiated professional charge	Subject to the Maternity Programme	M	
19.2	**Medical services and midwifery**				
19.2.1	For ante-natal consultations	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff	12 per pregnancy	M	
19.2.2	For pregnancy scans and other pregnancy related tests	100% of the lower of cost or recommended tariff	Scans and related tests – 2 per pregnancy	M	
19.2.3	For the delivery by a general practitioner, medical specialist or midwife				
19.2.4	For post-natal care by a midwife and other practitioners				

20.	**PROSTHESIS – INTERNAL AND EXTERNAL** Subject to the hospital benefit management programme and limits stipulated in paragraph 26				
20.1	Internal Prosthesis	100% of the cost			
20.2	External Prosthesis	100% of the cost	R81 249 per family	M	
21.	**RENAL DIALYSIS (ACUTE AND CHRONIC)** For consultations, visits and all services and materials associated with the cost of renal dialysis	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff	Unlimited, subject to Annexure E		Subject to the hospital benefit management programme, the prior approval of the Scheme and the conditions and limits stipulated in paragraph 26 and the PMB regulations
22.	**RADIOLOGY AND RADIOGRAPHY** Subject to the conditions and limits stipulated in paragraph 26				
22.1	**General radiology**				
22.1.1	In hospital: For diagnostic radiology tests and scans	100% of the lower of the cost or recommended tariff	Unlimited	M	
22.1.2	Out of hospital: For diagnostic radiology tests and scans	80% of the lower of the cost or recommended tariff	Subject to Day-to-Day limit	D	

22.2	**Specialised radiology**				
22.2.1	In-hospital: Magnetic Resonance Images, CT scans, PET scans and nuclear medicine (excluding nuclear medicines for treatment of	100% of the lower of cost or recommended tariff	Unlimited Co-payment of R1 500 on MRI and CT scans only	M	Subject to the hospital benefit management programme
	oncology), bone densitometry, angiograms and mammograms				
22.2.2	Out of hospital: Magnetic Resonance Images, CT scans, bone densitometry and mammograms	100% of the lower of cost or recommended tariff	Unlimited Co-payment of R1 500 on MRI and CT scans only	M	Subject to the hospital benefit management programme
23**.**	**REMEDIAL AND OTHER THERAPIES** Subject to the conditions and limits stipulated in paragraph 26				
23.1	For services in respect of: • Audiology • Dietetics • Hearing aid acoustics • Occupational therapy • Orthoptics • Podiatry • Speech therapy	80% of the lower of cost or recommended tariff	Subject to Day-to-Day limit	D	

24.	**SURGICAL PROCEDURES** For surgical procedures performed by a general practitioner, medical specialist and clinical technologist	100% of the lower of cost or recommended tariff	Unlimited	M	This paragraph expressly excludes services provided in respect of osseointegrated implants and orthognathic surgery (see paragraph 7.3), refractive surgery (see paragraph 14.5) and organ transplants (see paragraph 15) and pregnancy (see paragraph 19) Subject to the hospital benefit management programme, the disease management programme and the conditions and limits stipulated in paragraph 26
25	**SABMAS WELLNESS** Wellness benefits are provided as additional insured benefits, which do not contribute to the depletion of any other insured limits (or savings) specified elsewhere in these rules. Once available Wellness benefits have been used, normal category limits apply. Note: Except in the case of PMBs, any consultations and costs not specifically stated in this section but related to the specified tests will be paid from relevant day to day benefits (or savings)				

25.1	**Immunisation Programmes**				
25.1.1	Child immunisation programme: as per the Department of Health's recommended immunisation program	100% of the lower of cost or recommended tariff	As per the Department of Health's guidelines	M	
25.1.2	Tetanus diphtheria booster: as required	100% of the lower of cost or recommended tariff	As required	M	
25.1.3	Influenza vaccination: All beneficiaries: one every year	100% of the lower of cost or recommended tariff	One every year	M	
25.1.4	Pneumococcal vaccination: beneficiaries aged 60 years and older, and high-risk individuals: one every year	100% of the lower of cost or recommended tariff	One every year	M	
25.2	**Early Detection Programmes**				
25.2.1	Full general physical examination	100% of the lower of cost or recommended tariff	Subject to the GPs, Specialists and Nurses consultation limit	M	

25.2.2	Mammogram: females aged 40 years and older: every 2 years	100% of the lower of cost or recommended tariff. Allow sonar procedure reimbursement (subject to prior authorisation) – where patients are under the age of 40 and present with an abnormal	Every 2 years	M	To be funded from the wellness benefit
		mammogram result and require a sonar procedure to assist with further diagnosis.			
25.2.3	Prostate specific antigen test Male 40-49 years: one every 5 years Male 50-59 years: one every 3 years Male 60-69 years: one every 2 years Male aged over 70 years: one every year	100% of the lower of cost or recommended tariff	As indicated	M	
25.2.4	DEXA scan male and female older than 50 years: one every 3 years	100% of the lower of cost or recommended tariff	One every 3 years	M	

25.2.5	Health assessment tests: one every year • BMI (Body Mass Index): All adult beneficiaries • Blood sugar test (finger prick): All adult beneficiaries • Blood pressure test: All adult beneficiaries • Cholesterol test (Finger Prick): All adult beneficiaries	100% of the lower of cost or recommended tariff	One every year, as indicated	M	
25.2.6	Cholesterol blood test	100% of the lower of cost or recommended tariff	As indicated	M	
25.2.7	Blood sugar blood test	100% of the lower of cost or recommended tariff	As indicated	M	
25.2.8	HIV test: male and female: one every year HIV finger prick test: male and female: one every year	100% of the lower of cost or recommended tariff	One every year	M	To be funded from the wellness benefit

25.2.9	Pap smear: female: one every 3 years	100% of the lower of cost or recommended tariff	One every 3 years Consultation & Pathology subject to day-to-day limit	M	To be funded from the wellness benefit. PMB benefits subject to Annexure E
25.2.10	Glaucoma Test • Beneficiaries 40-49 years: once every 2 years • Beneficiaries 50+: once a year	100% of the lower of cost or recommended tariff	One every year	M	
25.2.11	Dentistry: General full mouth examination by a general dentist or oral hygienist (including sterile tray and gloves), plus polishing and scaling: one per beneficiary per year	100% of the lower of cost or recommended tariff	As indicated	M	

25.2.12	Maternity Blood Tests: Maternity Blood Tests: 1 test per female beneficiary per pregnancy, subject to registration on the maternity programme: • Antiglobulin Test (Coombs) • Full Blood Count • Grouping: Rh antigen • HIV Ab/Elisa (At least 2 per pregnancy) • Rubella-IgM: Specific antibody titer: ELISA/EMIT: Per Ag • Quantitative Khan VDLR or other Flocculation (TPHA) • Beta HCG Qualitative • Hepatitis B H306 Surface antigen	100% of the lower of cost or recommended tariff	As indicated, per pregnancy		Subject to registration on the maternity programme:
25.2.13	Colon Cancer Faecal Occult blood test	100% of the lower of cost or recommended tariff	One every 2 years	M	

	World Health Organization (WHO) Global Outbreak Benefit

	Basket of care which includes inhospital and out-of-hospital management and supportive treatment of global World Health Organization recognized disease outbreaks - COVID-19 - Monkeypox	100% of the lower of cost or recommended tariff for services within the basket of care.	In hospital: Unlimited Out of hospital: Subject to Day-to-Day limit	M	PMB benefits subject to Annexure E Subject to the Scheme's Designated Service Provider (DSP) protocols and clinical entry criteria. Treatment will be funded at 100% of cost at a designated service provider.
26.	**BENEFIT LIMITS**				
26.1	The benefits provided in terms of paragraphs 1 to 24 have annual limits as stipulated in this table.				
26.2	The **annual limit on day to day benefits** are as follows: Day to day benefits (Depicted by a D in this Annexure/table) are subject to category limits as indicated, and further subject cumulatively to the day to day benefit limits indicated below, depending on family size				
	Member without dependants (M0)	R24 258 per member			
	Member with one dependant (M1)	R32 343 per family			
	Member with two dependants (M2)	R38 895 per family			
	Member with three or more dependants (M3+)	R43 901 per family			

26.3 Dependant categories

Dependant categories are as follows:

Member without dependants	M0
Member with one dependant	M1
Member with two dependants	M2
Member with three dependants	M3

26.4 Savings account

See Annexure A1.

*Routine Benefit = day to day as per paragraph 26.2

26.5 List of chronic conditions

DIAGNOSIS	**DIAGNOSIS**
Addison's disease	Asthma
Bipolar mood disorder	Bronchiectasis
Cardiac failure	Cardiomyopathy disease
Chronic renal disease	Coronary artery disease
Chronic obstructive pulmonary disorder	Crohn's disease
Diabetes insipidus	Diabetes mellitus type 1 & 2

Dysrhythmias	Epilepsy
Glaucoma	Haemophilia
Hyperlipidaemia	Hypertension
Hypothyroidism	Multiple sclerosis
Parkinson’s disease	Rheumatoid arthritis
Schizophrenia	Systemic lupus erythematosus
Ulcerative colitis	HIV

26.6 Extended list of conditions (Benefits will be provided above the PMB entitlement for DTP conditions included in the list below)

1. MENOPAUSE
2. DEPRESSION *
3. OSTEOARTHRITIS
4. ANKYLOSING SPONDYLITIS
5. PARAPLEGIA/QUADRAPLEGIA *
6. STROKE
7. CARCINOID SYNDROME
8. DVT AND OTHER THROMBOSIS
9. HEPATOMYALGY & SPLENOMYALGY
10. CARDIAC DYSRYTHMIAS *
11. ENDOCARDITIS
12. CEREBROVASCULAR DISEASE *
13. PULMONARY HYPERTENSION *

14. HEART VALVE DISEASE *
15. POLYCYSTIC OVARIAN SYNDROME
16. CONGENITAL MALFORMATION.OF HEART *
17. CEREBRAL PALSY
18. GOUT
19. GORD
20. ALLERGIC RHINITIS
21. OSTEOPOROSIS
22. ADHD
23. ECZEMA
24. PSORIASIS
25. BENIGN PROSTATIC HYPERTROPHY *
26. ACNE
27. ALZHEIMER'S *
28. HYPOPARATHYROIDISM
29. Gigantomastia
30. Urinary incontinence

* Benefit will be provided above the PMB level of care / PMB DTP entitlement.