ANNEXURE B2

ESSENTIAL 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 per admission.

Except in the case of an emergency, any admission to a hospital outside of the defined network within the hospital benefit management programme, will require an upfront payment of R7 650.

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: SABMAS Pharmacy Network for the delivery of chronic medicines

(d) Hospital benefit management programme: Full cover at a Network hospital, as defined. An upfront payment shall apply to admissions outside of the defined network, as stipulated in Section B of this Annexure.

(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).

	OVERALL ANNUAL LIMIT (OAL) AND CATEGORY LIMITS: All limits depicted in this Annexure are annual limits, unless otherwise indicated. All benefits on the Essential Option are subject to category limits where indicated, and further subject collectively to an Overall Annual Limit (OAL) of R471 050 per family per annum as indicated in 26.2, for all benefits combined. Continued benefits apply for Prescribed Minimum Benefits (PMBs) after depletion of category limits and/or the OAL, 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	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	No benefit	No benefit	
3.	**AMBULANCE SERVICES**	100% of the cost		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	Subject to Overall Annual Limit	
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	R8 122 per family	

4.1.1	Hearing aids (once every three years)	100% of the cost	Once every three years, included in medical and surgical appliances limit	
4.1.2	Hearing aid repairs (once every 2 years)	100% of the cost	R3 397 per beneficiary once every 2 years	
4.2	Home oxygen, cylinders, concentrators and ventilation expenses excluding CPAP machines	100% of the lower of cost or recommended tariff	Subject to Overall Annual Limit and Annexure E	Subject to Annexure E
5.	**BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS**	100% of the cost	Subject to Overall Annual Limit	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. Member and each dependent have to select a primary and secondary care GP on joining the plan. Member and dependents can elect to change their chosen GP once a year.			

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	Subject to Overall Annual Limit	Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26
6.2	**Out of hospital:** Consultations and visits by general practitioners, homeopaths, and nurse practitioners in the supplier's	**Where member uses their selected GP:** 100% of the negotiated fee where applicable or 100% of the lower	R2 436 per beneficiary for all services combined, including surgical procedures and consumables	Subject to the conditions and limits stipulated in paragraph 26

	rooms or patient's home or primary health care facility	of cost or recommended tariff **Where member uses GP other than selected GP:** First 3 consultations at 100% of the lower of cost or negotiated fee Fourth consultation onwards at 60% of the lower of cost or negotiated rate		
6.2	**Out of hospital:** Consultations and visits by medical specialists in the supplier's rooms or patient's home or primary health care facility	80% of the negotiated fee where applicable or 80% of the lower of cost or recommended tariff where member is referred by a general practitioner	R2 374 per beneficiary for all services combined	Subject to the conditions and limits stipulated in paragraph 26

		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	Subject to Overall Annual Limit Single endoscopy: Copayment R5 000 Multiple endoscopy: Co-payment R6 250	Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26
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 tariff where member is	Single endoscopy: Copayment R5 000 Multiple endoscopy: Co-payment R6 250	Subject to the conditions and limits stipulated in paragraph 26

		referred by a general practitioner 60% of the negotiated fee where applicable or 80% of the lower of cost or recommended tariff where member is **not** referred by a general practitioner		
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. Network does not apply to any admissions related to trauma. 80% of the negotiated fee where applicable	Subject to Overall Annual Limit	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.

		or 80% of the lower of cost or recommended tariff if performed at a non-network facility.		
6.5	**Readmissions Prevention**: For defined clinically appropriate conditions and risk categories	80% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	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	80% of the lower of cost or recommended tariff	Subject to Overall Annual Limit 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 tariff	MO R3 890 M1 R6 419	

7.1.2	**Dental therapists** For basic dentistry performed by dental therapists	80% of the lower of cost or recommended tariff	M2 R7 551 M3+ R8 663 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	
7.1.3	**Oral hygienist** **For basic dentistry performed by an oral hygienist.**	80% of the lower of cost or recommended tariff. Subject to day to day limit.		

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	No benefit	No benefit	
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	No benefit	No benefit	
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	Subject to Overall Annual Limit	Subject to the hospital benefit management programme

7.5	**Maxillo-facial surgery**	100% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	Subject to the hospital benefit management programme See paragraph 24 (Surgical Procedures)
7.6	**Orthodontic treatment**	No benefit	No benefit	
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 (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	Subject to Overall Annual Limit	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	Subject to Overall Annual Limit	
8.1.3	For materials and hospital equipment and the transport of blood	100% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	
8.1.4	Medicines	100% of the lower of cost or the price	Subject to Overall Annual Limit	

		determined by the hospital benefit management programme plus the negotiated professional charge for medicines		
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.	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	Subject to Overall Annual Limit	

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 benefit management programme plus the	See paragraph 11.1.1	
		negotiated professional charge for medicines		
8.3	**Alternatives to hospitalisation: Step-down facility and private nursing** For all services rendered by private nursing and/or step down facilities	100% of the lower of the cost or recommended tariff	Subject to Overall Annual Limit	Subject to the hospital benefit management programme, the disease management programme and the conditions and limits stipulated in paragraph 26
8.4	**Alternatives to hospitalisation: Rehabilitation centres** For accommodation, services, consumables and equipment at an approved facility			

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	R49 258 per person per lifetime and Subject to Overall Annual Limit	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	Subject to Annexure E	

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	Subject to Annexure E	
9.3	**All other services related to HIV**	Subject to Annexure E	Subject to Annexure E	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	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 PMB 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	MO R3 757 M1 R6 163 M2 R6 973 M3+ R7 653 Further limited to R2 534 per female beneficiary for contraceptives	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. Refer to Annexure C 3.10 for additional covered items.
11.1.2	**Pharmacy advised therapy (PAT)**	No benefit	No benefit	

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	100% of the cost determined by the extended or chronic medication programme plus the negotiated dispensing fee if obtained from a	For 26 PMB CDL conditions only, subject to Annexure E Medicine Reference Pricing / MMAP applies	Subject to the extended or chronic medication programme and the conditions and limits stipulated in paragraph 26 Chronic list is detailed in paragraph 26
	an extended or chronic sickness condition	SABMAS Pharmacy Network; for non-use of the DSP, a 20% co-payment will apply		
	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 and Subject to the Overall Annual Limit	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 and included in acute medicine limits (paragraph 11.1.1)	See paragraph 11.1. Subject to acute medicine 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 negotiated tariff at network facility. 80% of the lower of cost or negotiated tariff at a non-network facility.	R29 005 per beneficiary, including in-hospital consultations and procedures	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		
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	Subject to and included in the limit of R30 687 for Mental Health - hospitalisation (paragraph 12.1)	PMB benefits subject to Annexure E
	For procedures of general practitioners, psychiatrists, psychologists and social workers	100% of the lower of cost or recommended tariff		
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	R4 859 per family for out of hospital consultations and procedures	
	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		

	Disease management for major depression for members registered on the Scheme's Disease Management Programme	80% of the lower of cost or recommended tariff	Subject to Overall Annual Limit 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	Subject to Overall Annual Limit	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	Subject to Overall Annual Limit	
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.	R1 948 per beneficiary every 2 benefit years	Combined limit for frames, readers and spectacle lenses
14.2	**Spectacle lenses prescribed or supplied by a registered**			

	optometrist, ophthalmolo or supplementary optical practitioner	Up to a maximum of 100% of the SAB Medical Scheme Rate. Subject to annual limits.		Frames limited to one pair of frames per beneficiary every 2 benefit years Spectacle lenses limited to one pair of lenses per beneficiary every 2 benefit years Readers must be obtained from a registered optometrist
14.3	**Contact lenses disposableand/or lenses contact (clinically essential)**	No benefit	No benefit	
14.4	**Eye examinations**	Optometry consultation and optometry not otherwise specified. Up to a maximum of 100% of the SAB Medical Scheme Rate. Subject to annual limits.	Subject to Overall Annual Limit	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**	No benefit	No benefit	
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 at an approved facility	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff	R69 607 per family	PMB benefits subject to Annexure E
15.2	For post- operative anti-rejection medicines	100% of the cost determined by the chronic medication programme plus the negotiated professional charge		
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 R200 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 and Overall Annual Limit	PMB benefits subject to Annexure E
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 and Overall Annual Limit	PMB benefits subject to Annexure E

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	Subject to the Overall Annual Limit	PMB benefits subject to Annexure E

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	Subject to Overall Annual Limit	
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 Overall Annual Limit	
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 (No benefit for chiropractors)	100% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	No benefit for chiropractors
18.2	**Out of hospital** For physiotherapy and biokinetics (No benefit for chiropractors)	80% of the lower of cost or recommended tariff	R2 102 per family	No benefit for chiropractors
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	Normal Deliveries – subject to the maternity programme and Overall Annual Limit Caesarean Sections – subject to the maternity programme and limited to R25 938 per confinement	Limit can be exceeded if clinically appropriate for non-elective caesarean sections, subject to the Overall Annual Limit.
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		

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 Subject to Overall Annual Limit	
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 Subject to Overall Annual Limit	
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**	100% of the cost	R71 300 per family	Limit accumulation subject to DSP usage in section C
20.2	**External**	100% of the cost		

21.	**RENAL DIALYSIS (ACUTE AND CHRONIC)** For consultations, visits and all services and materials associated with the cost of renal dialysis at an approved facility	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff	R62 361 per family	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 PMB benefits subject to Annexure E
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, scans, and mammograms	100% of the lower of the cost or recommended tariff	Subject to Overall Annual Limit	
22.1.2	**Out of hospital** For diagnostic radiology tests, scans, and mammograms	80% of the lower of the cost or recommended tariff	Subject to Overall Annual Limit	
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	Subject to Overall Annual Limit Co-payment of R1 500 on MRI and CT scans only	Subject to the hospital benefit management programme

	oncology), bone densitometry, and angiograms			
22.2.2	**Out of hospital** Magnetic Resonance Images, CT scans, and bone densitometry	100% of the lower of cost or recommended tariff	Subject to Overall Annual Limit Co-payment of R1 500 on MRI and CT scans only	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	R2 240 per family collectively for all services	
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	Subject to Overall Annual Limit	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 category limits			
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	

25.1.2	Tetanus diphtheria booster: as required	100% of the lower of cost or recommended tariff	As required	
25.1.3	Influenza vaccination: All beneficiaries: one every year	100% of the lower of cost or recommended tariff	One every year	
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	
25.2	**Early Detection Programmes**			
25.2.1	Full general physical examination	100% of the lower of cost or recommended tariff	Subject to the GP and nurse practitioners Consultation Limit	
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	Every 2 years	To be funded from the wellness benefit

		patients are under the age of 40 and present with an abnormal 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	
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	
25.2.5	Health assessment tests: one every year • BMI (Body Mass Index): All adult beneficiaries • Blood sugar test (finger prick): All adult beneficiaries	100% of the lower of cost or recommended tariff	One every year, as indicated	

	• Blood pressure test: All adult beneficiaries • Cholesterol test (Finger Prick): All adult beneficiaries			
25.2.6	Cholesterol blood test	100% of the lower of cost or recommended tariff	As indicated	
25.2.7	Blood sugar blood test	100% of the lower of cost or recommended tariff	As indicated	
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	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 Overall Annual Limit	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	

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	
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 titre: 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	

	World Health Organization (WHO) Global Outbreak Benefit			
	Basket of care which includes in hospital 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.	Subject to Overall Annual Limit	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 the table above.			
26.2	**OVERALL ANNUAL LIMIT (OAL)** R471 050 per family All benefits on the Essential Option are subject collectively to an annual overall limit of R471 050 per family; subject to an inner category limit, where indicated.			
26.3	Where no limitation of the benefit is indicated as a category limit, the benefit is only limited to the overall annual limit.			
26.4	**Dependant categories** Dependant categories are stated thus: Member without dependants M0 Member with one dependant M1 Member with two dependants M2 Member with three or more dependants M3+			

26.5 **List of chronic conditions**

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
Depression	Epilepsy
Dysrhythmias	Haemophilia
Glaucoma	Hypertension
Hyperlipidaemia	Multiple sclerosis
Hypothyroidism	Rheumatoid arthritis
Parkinson's disease	Systemic lupus erythematosus
Schizophrenia	HIV/Aids

Ulcerative colitis	

* In addition, to the above chronic conditions, chronic conditions listed in the PMB DTP List will be covered in accordance with the PMB DTP entitlement