SAB
The South African Breweries | Medical Aid

SAB MEDICAL AID BENEFIT GUIDE

2025

CONTENTS

The proposed changes are subject to approval by the Council of Medical Schemes (CMS).

CONTENTS

SOUTH AFRICAN **MEDICAL SCHEMES**

There are two kinds of medical schemes, namely, open and closed (restricted) schemes. Any person can join an open scheme, but closed schemes are for the employees of specific employer groups or membership of a particular profession, industry, association or union.

TYPES OF MEDICAL AID PLANS:

TRADITIONAL

These are usually closed corporate medical schemes. Contributions from all members are pooled and all medical claims are paid using funds from the medical scheme's pool of money. The size of the pool determines what benefits can be covered for all members.

Limits start fresh each year, so if you don't use a particular benefit in a particular year, it doesn't carry over to the next year.

In essence, traditional cover generally means that most of your medical expenses are covered from the medical scheme's pool of money within the rules and benefits of the medical scheme and up to certain limits.

NEW GENERATION

These are open medical schemes like Discovery Health Medical Scheme, Momentum Health, Bonitas Medical Scheme, Sizwe Hosmed Medical Scheme and others. They generally cover major medical costs like hospitalisation and chronic medicine from the medical scheme's pool of money, but day-to-day expenses, like visits to a GP, dentist, optometrist, X-rays, and medicine come out of the member's own savings account. If savings aren't fully used, they carry over to the next year.

HOW THE SCHEME WORKS

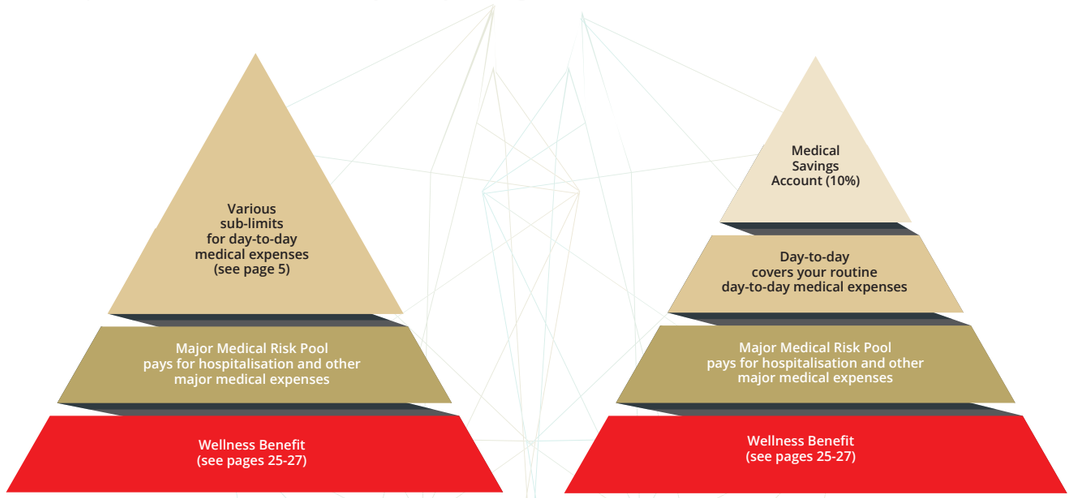
As you know, health is unpredictable and the costs of quality healthcare in South Africa are rising all the time. Even if you take good care of yourself and your health, you don't want to be caught off guard by an accident, an unforeseen illness or even the high costs of a pregnancy, appendectomy or X-rays.

In our country, the Medical Schemes Act (131 of 1998) regulates all medical schemes. Since the healthcare industry is constantly evolving and undergoing changes, so does SAB Medical Aid undergo changes to ensure that it stays abreast of industry developments. This allows members to make the most informed and most appropriate choices possible within SAB Medical Aid.

WHAT ABOUT **SAB MEDICAL AID?**

SAB Medical Aid is a closed corporate medical scheme. We aim to give our members the best of both worlds.

The **Essential Option** is considered a traditional medical scheme option. The **Comprehensive Option** is also a traditional medical scheme option with a savings element. These savings are used for co-payments and discretionary medical spend (such as over-the-counter medicine and fees higher than the Scheme Rate). We also offer our members something unique: both Options have a wellness component to them, which encourages health awareness and provides peace of mind via preventative care and early detection. Review the Option comparison on page 5 so that you can easily identify the Option with the benefits that will suit you and your budget.



ESSENTIAL VS COMPREHENSIVE

CHANGING BETWEEN OPTIONS

Please note that you can only change between the Comprehensive and Essential Options at the end of the year for the following year. Specific dates for the Option change window period are published online at **www.sabmas.co.za.** During this time, you can change either from Essential to Comprehensive, or vice versa. Please remember that Option changes take effect on 1 January each year.

CHOOSING THE RIGHT BENEFIT OPTION

The table below gives you a brief summary of the different benefits and inclusions we offer on the Essential and the Comprehensive Options. See at a glance the benefits offered for each Option to help you make an informed decision.

	ESSENTIAL	COMPREHENSIVE
Overall Annual Limit	▪ An overall annual limit applies R521 809 per family*	▪ Unlimited
Medical Savings Account	▪ No savings	▪ 10% savings ▪ This always remains the members'
Major medical benefits	▪ Acute Hospital Network ▪ Specialist Network (if you use a non-network specialist, you may have to pay for out-of-pocket expenses)	▪ Hospital of choice except for PMB*** ▪ Specialist Network (if you use a non-network specialist, you may have to pay for out-of-pocket expenses) ▪ Refractive surgery ▪ Specialised dentistry benefits, subject to limits
	Subject to pre-authorisation, limits and patient advocacy	
Chronic Benefit	▪ 26 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions ▪ Network Providers – SABMAS Pharmacy Network (20% co-payment if you use a non-Network Provider)	▪ 26 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions + 29 additional non PMB CDL conditions ▪ Network Providers – SABMAS Pharmacy Network (20% co-payment if you use a non-Network Provider)
	Subject to medicine reference pricing and approval	
Day-to-Day Benefit	▪ Subject to overall annual limit with certain sub-limits (GPs, specialists, dentists, acute medicine, physiotherapy and biokinetics, remedial and other therapies) ▪ No savings ▪ 20% co-payment deducted from salary, or is deducted by debit order if you are a self-paying member ▪ Increased Optical Benefit ▪ Unused benefits are not carried over to the next year	▪ Subject to certain sub-limits (GPs, specialists and dentists) ▪ 10% savings ▪ 20% co-payment payable from savings or deducted from salary, or is deducted by debit order if you are a self-paying member ▪ Enhanced Optical Benefit ▪ Unused savings balances are carried over each year ▪ Unused benefits are not carried over to the next year
Consultations and visits with a GP (out-of-hospital)	▪ For your chosen GP or 3 consultations with a different GP: 100% of the lower of cost or Scheme Rate R2 699 per beneficiary including minor procedures and consumables. For a GP who has not been chosen, where 3 consultations have been depleted: 60% of the lower of cost or Scheme Rate	▪ 100% of the lower of cost or Scheme Rate R5 649** per beneficiary including minor procedures and consumables.
Consultation and visits with specialists (out-of-hospital)	▪ If referred by GP: 80% of the lower of cost or Scheme Rate R2 629 beneficiary. If not referred by GP: 60% of the lower of cost or Scheme Rate. R2 629 per beneficiary	▪ If referred by GP: 80% of the lower of cost or Scheme Rate R5 948** per beneficiary. If not referred by GP: 60% of the lower of cost or Scheme Rate. R5 948 per beneficiary
Wellness Benefit	A basket of early detection and preventative tests paid from the Scheme's risk pool, which helps your Day-to-Day Benefit last longer and keeps you on track with your health status	
Prescribed Minimum Benefits (PMB)	▪ 100% of the lower of submitted or contracted fee in respect of diagnosis, treatment and care costs of prescribed minimum benefit conditions if those services are obtained from a designated service provider	▪ 100% of the agreed rate for the diagnosis, treatment and care costs of PMB conditions, if those services are obtained from a Network Provider. Benefits may be subject to preauthorisation and/or managed care protocols
Monthly contributions	▪ Lower, as there are limited benefits and restricted access	▪ Higher, as there are richer benefits and more freedom of choice

* All claims accumulate to this limit. Once the available sub-limit and/or annual limit has been reached, you will only have cover for PMB treatment.
** This is a shared limit for GP and Specialist Out-of-Hospital consultations.
*** See page 17 for all the hospitals in the Acute Hospital Network.

WHAT WE COVER

DAY-TO-DAY BENEFITS

We are one of the very few medical schemes to offer you both a savings account (on the Comprehensive Option) and Traditonal Benefits. The value of the Traditional Benefits will differ depending on your family size.

1. THERE'S AN 80/20 CO-PAYMENT STRUCTURE

When you claim for a specialist or dentist consultation, the Scheme pays 80% of the Scheme Rate. The other 20% is first paid from your available savings if you're on the Comprehensive Option, otherwise it comes off your salary, or is deducted by debit order if you are a self-paying member.

2. THERE ARE SET LIMITS AND SUB-LIMITS

Please refer to page 21, which will take you through the limits and sub-limits of certain benefits so that your savings (if you're on the Comprehensive Option) can go further.
If you are on the Essential Option, and have depleted your limits, you will need to pay from your own pocket.

Remember:
If your doctor charges more than the Scheme Rate, you will need to pay the extra amount above the Scheme Rate. This amount above the Scheme Rate can be funded from your available savings (Comprehensive Option).

CHRONIC BENEFITS

CHRONIC TREATMENT PROTOCOL PROGRAMME FOR PRESCRIBED MINIMUM BENEFIT (PMB) CHRONIC DISEASE LIST (CDL)

LIST OF CHRONIC CONDITIONS

The conditions covered under the SAB Medical Aid's (SABMAS) chronic medicines benefit are listed in this document. The list includes the conditions on the PMB CDL.

THE PRESCRIBED MINIMUM BENEFIT (PMB) CHRONIC DISEASE LIST (CDL)

In terms of the Medical Scheme Act Regulations that came into effect on 1 January 2004, medical schemes are required to fund the cost of the diagnosis, medical management (consultations and procedures) and medication of a specified list of chronic conditions (see table 1). This list of conditions is referred to as the PMB CDL. All of these conditions are covered by SABMAS.
In terms of the legislation, a medical scheme may limit the treatment in accordance with the gazetted therapeutic algorithms and apply managed care interventions to improve the efficiency and effectiveness of healthcare provision.

REGISTRATION OF CHRONIC CONDITIONS

Members can only access the chronic benefit if their prescribing/treating doctor has REGISTERED their chronic condition(s) and medication with the SABMAS Chronic Team on 0860 002 133. This applies to all eligible chronic conditions.

Newly diagnosed chronic conditions
If a member is diagnosed with a new chronic condition listed on table 1 during the course of the year, registration of the chronic condition is required before access to chronic medication, procedures and consultation benefits will be granted.

Who can register the chronic condition?
As detailed clinical information, including the condition's ICD-10 code, severity status and pathology results where applicable, are required to register a member's chronic condition, the treating doctor is required to register the member's chronic condition.

Once a member's condition has been registered, a member will have access to the CONDITION MEDICINE LIST (CML). This is a list of medication, appropriate for the condition that does not require pre-authorisation– these are automatically authorised

PRE-AUTHORISATION

The CML does not list all medication that may be required to treat a member's condition. Some medication requires specific pre-authorisation. As detailed clinical information is required to pre-authorise this medication, the treating doctor is requested to obtain this authorisation from SABMAS Chronic Team on 0860 002 133.

All existing SABMAS exclusions and limitations apply.

Once the condition is registered, contact with the Scheme is only required if the chronic medication prescribed is not included in the list for the registered condition, or if the member does not want to pay the price difference between medication and there are grounds for possible overriding of the co-payment.

If the member does not want to pay the co-payment, the prescribing doctor can consider changing the medication to an alternative medication with no co-payment, by contacting the SABMAS Chronic Team on 0860 002 133.

Note: There is a web-based search available to assist members in determining whether they will be liable for a co-payment on their chronic medication:

1. Log on to **www.sabmas.co.za**.
2. Click on the Home Page.
3. Select the Find an alternate medicine in the right hand menu.
4. Select the Option from the drop down menu.
5. Insert the name of the product or the condition in the drop down menu.
6. Follow the prompts

Alternately **click here** to access the alternate medicine search.

SPECIAL BENEFIT AUTHORISATIONS

Oncology and organ transplant medication requests must be referred to the SABMAS Chronic Team on 0860 002 133 or emailed to chronic@sabmas.co.za or oncology@sabmas.co.za For HIV/AIDS authorisations, please contact Aid for AIDS (AFA) on **0860 100 646**.

Please note: The CML is not a fixed list of products. It is constantly revised and updated in accordance with new products registered, discontinued products, price changes, as well as changes to product registration details.

TABLE 1 LIST OF PMB ELIGIBLE CHRONIC DISEASE CONDITIONS

1. Addison's Disease
2. Asthma
3. Bipolar Mood Disorder
4. Bronchiectasis
5. Cardiac Failure
6. Cardiomyopathy
7. Chronic Renal Disease
8. Chronic Obstructive Pulmonary Disorder
9. Coronary Artery Disease
10. Crohn's Disease
11. Diabetes Insipidus
12. Diabetes Mellitus Types 1 and 2
13. Dysrhythmias
14. Epilepsy
15. Glaucoma
16. Haemophilia
17. HIV/AIDS
18. Hyperlipidaemia
19. Hypertension
20. Hypothyroidism
21. Multiple Sclerosis
22. Parkinson's Disease
23. Rheumatoid Arthritis
24. Schizophrenia
25. Systemic Lupus Erythematosus
26. 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.

TABLE 2 LIST OF NON PMB CHRONIC CONDITIONS

1. Acne
2. Adhd
3. Allergic Rhinitis
4. Alzheimer's *
5. Ankylosing Spondylitis
6. Benign Prostatic Hypertrophy *
7. Carcinoid Syndrome
8. Cardiac Dysrythmias *
9. Cerebral Palsy
10. Cerebrovascular Disease *
11. Congenital Malformation Of Heart *
12. Depression *
13. Dvt And Other Thrombosis
14. Eczema
15. Endocarditis
16. Gord
17. Gout
18. Heart Valve Disease *
19. Hepatomyalgy & Splenomyalgy
20. Hypoparathyroidism
21. Menopause
22. Osteoarthritis
23. Osteoporosis
24. Paraplegia/Quadraplegia *
25. Polycystic Ovarian Syndrome
26. Psoriasis
27. Pulmonary Hypertension *
28. Stroke
29. Urinary Incontinence

**** Benefit will be provided above the PMB level of care / PMB DTP entitlement for Comprehensive Option only***

Prescribed Minimum Benefits (PMB) and the Chronic Disease List (CDL)

All medical scheme members have access to a certain minimum level of health services. PMBs are defined in the Regulations to the Medical Schemes Act as the level of minimum benefits available to all members and their dependants.

To ensure that you have full cover for the treatment of your PMB condition in hospital, we have created a Hospital Network for PMBs. The Acute Hospital Network will serve as the Scheme's PMB Hospital Network for both the Comprehensive and Essential Option.

When you make use of the Acute Hospital Network along with a Healthcare Provider in the SABMAS Provider Network, we will pay your hospitalisation and related provider claims in full at Scheme rate.

Please refer to page 17 for the list of hospitals within the Acute Hopsital Network and visit www.sabmas.co.za to search for a Healthcare Provider.

As part of PMBs, 26 chronic conditions, including HIV/AIDS, on the CDL are covered, as well as any chronic condition included in the 270 PMBs. The 270 PMB conditions are linked to a specific diagnosis and treatment guideline known as Diagnosis and Treatment pairs. Members will receive treatment for conditions on this list, subject to registration, approval, formularies and use of a Network Provider.

To view the complete list of PMB conditions, please visit **www.medicalschemes.co.za**

CHRONIC CARE MANAGEMENT

The Scheme applies clinical guidelines to assess each chronic application and ensure the suggested medicines are appropriate, correctly prescribed and cost effective. You will need to apply for all Chronic Benefits.

Remember:

Our chronic medicine application process is telephonic and real-time. Ask your doctor to contact the Customer Care Centre on 0860 002 133 and speak to a Clinical Consultant to approve your medicine.

REFERENCE PRICE AND MEDICINE MANAGEMENT

South African Breweries Medical Scheme applies two types of Reference Pricing:

MMAP refers to the maximum price the Scheme will pay for generic drugs and this price is the same per product for both plans, and Therapeutic Reference Pricing refers to the maximum price that the Scheme will pay for a specific therapeutic category of drugs. This reference price is based on the cost of drugs from the same, or a similar drug class listed on the CML. The therapeutic reference price differs from one plan to another.

The Scheme applies both reference pricing systems simultaneously and will only reimburse a product at the lower of the two prices applicable to the particular plan. If a product is prescribed that is above any of the relevant reference prices, you will need to pay the difference in price at the point of dispensing.

EXAMPLE A

Member has hyperlipidaemia (high cholesterol) and requires chronic medicine. They do NOT use a Network pharmacy and refuse to try a less expensive alternative.

Medicine: Lipitor costs: R280.85 (incl. dispensing fee)

Cost of less expensive alternative covered by Scheme: R45.99 (The member must pay R234.86 to the pharmacy)

A member who uses a non-network pharmacy will have an additional 20% co-payment of R9.19, which he or she must pay to the pharmacy at the point of sale, i.e. final cost covered by the Scheme will be R36.80 (R45.99 less R9.19) if a non-network pharmacy is used.

FINAL COSTS

Paid by Scheme: R36.80
Paid by member: R244.05

EXAMPLE B

Member has hyperlipidaemia (high cholesterol) and requires chronic medicine. Member uses a Network Provider and takes the less expensive alternative that the Scheme pays for.

Medication: Therapeutic alternative Atorvastatin costs: R45.99 (incl. dispensing fee)

As the pharmacy is part of the Network, the Scheme will pay the claim in full to the amount of R45.99.

Chronic medication is paid 100% and for Acute medication a 20% surcharge is applied.

FINAL COSTS

Paid by Scheme: R45.99
Paid by member: R0.00

ADVANCED ILLNESS BENEFIT (AIB) AND COMPASSIONATE CARE BENEFIT (CCB)

Through the Advanced Illness Benefit (AIB), SABMAS will ensure that members with advanced cancer have access to comprehensive palliative care that offers quality care in the comfort of their own home, with minimum disruption to normal routine and family life. In the same way, the Compassionate Care Benefit (CCB) will offer these additional benefits to members who have advanced diseases.

CHOOSING A PHARMACY

1. Remember that if you use a pharmacy in our Network your out-of-pocket expenses can be reduced. More than 90% of pharmacies in South Africa are part of our Network. Visit **www.sabmas.co.za** and look under *Pharmacy Network* where you will find a list of SABMAS Network Providers.

2. If you choose not to use a pharmacy in our network, you should shop around. Ask each pharmacy what their dispensing fee is (in short, how much they add to the cost of the medicine for giving it to you).

3. When the pharmacist dispenses medicine, feel free to ask if there's a less expensive generic or alternative. Pharmacists are qualified and required by law to substitute with cost-effective generic medication, unless otherwise mentioned on your prescription.

4. Question any co-payments (amounts you have to pay from your own pocket) and find out the reason behind the co-payment – like Reference Pricing and dispensing fees.

TREATMENT BASKETS FOR THE PRESCRIBED MINIMUM BENEFIT (PMB) CHRONIC DISEASE LIST (CDL) CONDITIONS

Members who are registered with a chronic condition that falls within the Chronic Disease List conditions listed as Prescribed Minimum Benefits, will now be eligible for a new chronic medicine basket. This includes defined tests and a limited number of specialist consultations, all of which are covered up to the Scheme Rate for each year.

To view the document on treatment baskets that lists the procedures, investigations and specialist consultations we cover for your approved PMB CDL conditions, visit www.sabmas.co.za.

The number of tests and consultations are calculated based on the number of months left in the year at the time we approve cover for your condition. If you have cover for the same procedures or tests from more than one basket, we limit funding to the basket that gives you the most procedures or tests.

It is important that the correct ICD-10 code is used when your claim is submitted to the Scheme. This is to make sure we pay from the correct benefit.

If you need more cover than what is included in the treatment basket, your doctor may follow an appeals process to request extra funding for the tests, procedures and consultations you need. Your doctor needs to complete a form titled: Request for additional cover for approved Chronic Disease List conditions, which can be downloaded from our website at www.sabmas.co.za and sent back to us for review. It is important to note that an appeals process does not guarantee approval for the additional cover.

MAJOR
MEDICAL BENEFITS

It probably won't surprise you to hear that hospitalisation is the most expensive benefit we provide. All those scans, surgeries and specialists cost a fortune in hospital. The Major Medical Benefit gives you cover for hospitalisation and certain out-of-hospital procedures. These procedures can be performed in a doctor's room, a registered day clinic or an outpatient facility, if treatment is clinically appropriate and pre-authorised.

PRE-AUTHORISATION

You need to get pre-authorisation for planned admissions, **before** being admitted to hospital, as well as for certain out-of-hospital procedures. But in an emergency, when there's no time to think about these things, we make an exception – so you can get authorisation afterwards. This must be done within 48 hours of admission to avoid penalties. (Also, please see the Netcare 911 information on page 29).

To get pre-authorisation, call 0860 002 133 and have the following information on hand:

- Membership number
- Name of admitting doctor
- Name of hospital
- Diagnosis
- The diagnostic code/s (called the ICD-10 code)
- Procedure to be performed – with relevant tariff codes.

You will get this information from the Healthcare Provider referring you to hospital. Pre-authorisation is given once benefits have been checked and the Scheme Rules have been applied. As an example, if you are on the Essential Option, we check to see whether you have used all your benefits. If a hospital or a doctor obtains authorisation on your behalf, you are responsible for obtaining the information that has been given to your hospital or doctor.

Please Note:

If you do not get pre-authorisation for a planned procedure, you may have to pay the full account yourself.

BENEFIT CHANGES FOR 2025

1

Postpartum Depression & Anxiety Support Programme

- Enhanced maternity benefits, building on those introduced in 2024.
- Identification of postnatal depression/anxiety during post-birth check-ins.
- A one-hour online consultation with a psychologist.
- Two group sessions per month, for six months, with a SADAG-trained support group.
- A post-birth depression journal, delivered to your door.

2

Childbirth Antenatal Classes & Rewards

- Four live online classes per month for expectant mothers.
- An electric single breast pump with milk storage bags as a reward for participation.

3

Haematinics for Comprehensive Plan Members

- Comprehensive Plan members will now receive coverage for acute haematinics (for treating anaemia) under risk benefits, reducing the need to dip into medical savings accounts (MSA).

4

Hospital at Home (HAH) Benefit

- Hospital-level care at home for specific conditions, provided by Quro Medical, to help reduce hospitalisation costs while ensuring you receive quality care in the comfort of your home.

5

Specialist Reimbursement Adjustments

- Revised reimbursement rates for several specialist disciplines, including gastroenterology, neurology, ophthalmology, orthopedic surgery, ENT, and cardiology, to align with industry standards. We have also adjusted rates for family physicians following their reclassification as specialists.

PATIENT ADVOCACY

SAB Medical Aid is consistently at work to add a large range of Healthcare Providers to our SABMAS Provider Networks for your convenience. Our SABMAS Provider Networks have been contracted to the Scheme to provide you with quality healthcare at negotiated rates. Negotiated rates are paid in full by the Scheme, protecting you from out-of-pocket expenses and therefore saving you money. It is each member's responsibility to ensure that you are consulting with a provider in the Network.

Visit **www.sabmas.co.za** to search for a Healthcare Provider in your area.

MEDICAL PROCEDURES

Medical procedures often include services from more than one Healthcare Provider. Please contact our Customer Care Centre on **0860 002 133** to determine if the Healthcare Provider involved in your procedure form part of the Network. You will benefit from using specialists on this Network, as they charge the agreed reimbursement rate, therefore the claim will be settled in full by the Scheme without any co-payments payable by the member.

If you do not use Healthcare Providers that form part of the Network, please ensure that you negotiate reduced rates prior to the procedure, as you will be liable for the shortfall between the rates charged and the Scheme's Rate.

A little preparation will go a long way to curb exorbitant medical costs, making sure you get the right quality treatment at the right cost.

SAB MEDICAL AID PROVIDER NETWORKS

GENERAL PRACTITIONER NETWORK

Our GP Network consists of Preferred Providers who have contracted with the Scheme in order to provide you with quality care at an affordable rate.

If you visit a medical practitioner who forms part of our GP Network, the provider will not charge more than the contracted rate.

All members on the Essential Option are required to choose a GP in the Network to visit. If you see your chosen GP, 100% of the agreed or Scheme Rate will be covered, and the 20% will be the member portion If you choose to visit a GP who is not your chosen GP, you will be entitled to three out-of-network (OON) GP consultations, (This includes consultation and minor procedures done in the GP's consulting rooms).

The fourth (OON) consultation onwards will be covered at 60% of the lower of cost or Scheme rate.

SABMAS PHARMACY NETWORK

You are free to choose from the wide range of pharmacies in our Network. Refer to page 11 for more information.

SPECIALIST NETWORK

This is the group of specialists we've negotiated with to give you quality healthcare services at specified rates. If you decide to use a specialist who's not on our list, and who charges more than our Scheme Rate, you will have to pay for the additional cost. All members are required to consult a GP before seeing a Specialist. If you go straight to the Specialist, SABMAS will only pay 60% of the Scheme Rate.

CENTRE FOR DIABETES AND ENDOCRINOLOGY

The **Diabetes management benefit programme** is provided by the Cardiovascular Diabetes Education (CDE) Healthcare Group. This collaboration offers you access to specialised diabetes-related consultations and services at no additional costs to the member. **For further information, please contact the CDE Membership Department. Email: members@cdediabetes.co.za / Call: 011 053 4400**

CHRONIC CARE REHABILITATION PROGRAMMES (BACK & NECK)

The implementation of the **chronic care rehabilitation programmes** for back, neck, hip, knee, and shoulder offered through Workability is designed to help members living with chronic musculoskeletal pain take back control of their lives and activities. They have a national network of 96 practices. https://workability.co.za/find-a-practice. **The Scheme will identify individuals who are eligible to enter the programme; however, if you feel that you may qualify for and benefit from this programme, send an email to referrals.network@workability.co.za, and one of their case managers will be in touch to guide you through the process.**

HOW THINGS WORK

The below example has been done to explain how using a Network provider can help save you from out-of-pocket expenses.

Before you even make the appointment to see a Healthcare Provider, you can log in to our website at www.sabmas.co.za and use our self-help search tool Find a HealthCare Professional, to identify a Network Provider in your area.

BELOW IS AN EXAMPLE OF HOW THE SPECIALIST NETWORK WORKS

A	B	C
1 | The specialist is not on the SABMAS Specialist Network. You request the details of a specialist who is.	1 | The specialist of your choice is not on the SABMAS Specialist Network. You decide not to switch to a provider who is.	1 | You meet with the non-network specialist who takes you through the procedure.
2 | You visit the new specialist to discuss the procedure. You are prepared with questions: What will be done? How long will I stay in hospital? Who is the anaesthetist you partner with? Are they on the SABMAS Specialist Network? If not, can you choose one who is? (Remember, you are the consumer).	2 | You meet with the specialist, who takes you through the procedure.	2 | You contact our Customer Care Centre. The agent takes you through the Patient Advocacy process, see page 14 for more information.
3 | Now that you have all the details of your procedure (not just a weird code), you contact the Customer Care Centre and check if all the costs will be covered.	3 | You contact the Customer Care Centre to get your authorisation number. They give you authorisation for the procedure and inform you of the portion of costs you have to pay. In addition, you'll receive an email or an SMS to confirm all your authorised benefits.	3 | You go back to the non-network specialist and discuss the costs. You try to negotiate on rates or a discount for payment upfront. You ask questions such as how long it will take, what's involved, the anaesthetist and their rates, etc.
4 | The Customer Care Centre may have one or two questions.	4 | You undergo the procedure.	4 | The non-network specialist agrees on a discounted rate. You undergo the procedure. You know what you are in for. You have been a savvy consumer and have taken control of your healthcare.
5 | You call the specialist to ask questions. Everything is clarified; you are good to go. In addition, you'll receive an email or an SMS to confirm all your authorised benefits.	5 | You get the bill from the specialist and the anaesthetist (oops, you forgot about them!).	5 | Next time, you look into the SABMAS Specialist Network first. Less hassle; less running around.
6 | Your procedure did not result in nasty surprises. You were an informed patient.	6 | You may have to pay thousands of rands. Why so much? Because you used a specialist outside the Network, whose rate was way above our Scheme Rate.	

ACUTE HOSPITAL LIST

Essential Option members are covered in full at hospitals in the Acute Hospital Network in accordance with your option benefits. For planned admissions to any other private hospital, you must pay an upfront co-payment of 20%. This does not apply in an emergency.

While members on the Comprehensive Option may use any private hospital without an upfront payment, remember that these private hospitals represent the Scheme's **PMB Hospital Network** for both Options. This means you will have full cover for your PMB condition when using any of these hospitals along with a Healthcare Provider in the SABMAS Provider Network. You also have access to more than **95 Day Clinics** around the country.
Please visit our website at www.sabmas.co.za or call us on 0860 002 133 to find out more.

G GAUTENG

- Arwyp Medical Centre
- Clinix Botshelong Empilweni Clinic
- Clinix Naledi Nkanyezi Hospital
- Clinix Selby park Hospital
- Dr SK Matseke Memorial Hospital
- Life Bedford Gardens
- Life Brenthurst
- Life Carstenhof
- Life Flora Hospital
- Life Fourways Hospital
- Life Genesis Clinic
- Life Groenkloof Hospital
- Life Robinson Private Hospital
- Life Roseacres Hospital
- Life Springs Parkland Hospital
- Life Suikerbos Clinic
- Life Wilgeheuwel Hospital
- Life Wilgers Hospital
- Lenmed Ahmed Kathrada
- Lenmed Zamokuhle Hospital
- Louis Pasteur hospital
- Mediclinic Emfuleni
- Mediclinic Kloof
- Mediclinic Legae Private Hospital
- Mediclinic Medforum
- Mediclinic Morning side
- Mediclinic Midstream (Cardiac electrophysiology centre of excellence – admissions allowed for all arrhythmia related conditions)
- Mediclinic Sandton
- Milpark Hospital (Cardiac electrophysiology centre of excellence – admissions allowed for all arrhythmia related conditions)
- Midvaal Private Hospital
- Naledi Nkanyezi Hospital
- Nelson Mandela Children's Hospital
- Netcare Akasia
- Netcare Alberton
- Netcare Femina
- Sunninghill Nursing Home (Cardiac electrophysiology centre of excellence – admissions allowed for all arrhythmia related conditions)
- Unitas Hospital
- Wits Donald Gordon Medical centre
- Zuid-Afrikaans (Cardiac electrophysiology centre of excellence – admissions allowed for all arrhythmia related conditions)

L LIMPOPO

- Mediclinic Limpopo
- Tzaneen Mediclinic
- Zoutpansberg

M MPUMALANGA

- Life Cosmos
- Mediclinic Nelspruit

E EASTERN CAPE

- Life East London
- Life Mercantile Hospital
- Life St Georges Hospital
- Life St Marys

K KWAZULU NATAL

- Gateway Private Hospital (Cardiac Electrophysiology centre of excellence - admissions allowed for all arrhythmia related conditions)
- Hibiscus Hospital
- Hillcrest Private Hospital
- Lenmed Ethekwini Hospital and Heart Centre (including Cardiac Electrophysiology centre of excellence - admissions allowed for all arrhythmia related conditions)
- Lenmed La Verna Private Hospital
- Life Chatsmed Garden Hospital
- Life Empangeni Private Hospital
- Life Entabeni Hospital
- Life Westville Hospital
- Mediclinic Newcastle Hospital
- Mediclinic Pietermaritzburg
- Midlands Medical Centre
- St Augustine (Cardiac electrophysiology centre – arrhythmia conditions only)

N NORTH WEST

- Clinix Victoria Itokolle
- Mediclinic Potchefstroom
- Netcare Ferncrest

N NORTHERN CAPE

- Lenmed Health Kathu Hospital
- Mediclinic Upington
- Netcare Kokstad

F FREE STATE

- Busamed Harrismith
- Horizon Eye Care Centre
- Hoogland Mediclinic
- Life Rosepark Hospital
- Mediclinic Bloemfontein
- Mediclinic Welkom
- Netcare Universitas Private Hospital

W WESTERN CAPE

- Christiaan Barnard Memorial (Cardiac Electrophysiology centre of excellence - admissions allowed for all arrhythmia related conditions)
- Life Kingsbury Hospital (Ophthalmology and peripheral vascular surgery only)
- Life Peninsula Hospital
- Life Vincent Pallotti Hospital
- Mediclinic Cape Town
- Mediclinic Constantiaberg
- Mediclinic George
- Mediclinic Hermanus
- Mediclinic Panorama
- Mediclinic Stellenbosch
- Mediclinic Vergelegen
- Mediclinic Winelands Orthopaedic Hospital
- Melomed Bellville (Cardiac Electrophysiology centre of excellence - admissions allowed for all arrhythmia related conditions)
- Melomed Gatesville
- Melomed Mitchells Plain
- Melomed Tokai (Cardiac Electrophysiology centre of excellence - admissions allowed for all arrhythmia related conditions)
- Netcare Kuilsriver Hospital

YOUR BENEFIT **OPTIONS**

ESSENTIAL 2025

BENEFITS	ESSENTIAL OPTION	ESSENTIAL MONETARY LIMIT R521 809 OVERALL ANNUAL LIMIT PER FAMILY (M)	
OUT-OF-HOSPITAL BENEFITS IS SUBJECT TO OVERALL ANNUAL LIMIT			
ROUTINE		There are no Routine limits on this Option. Benefits are subject to the category sub-limits listed below, as well as the Overall Annual Limit. Member liable for a co-payment where applicable.	
ALTERNATIVE HEALTHCARE SERVICES	Acupuncture, naturopathy and osteopathy	No Benefit.	–
CONSULTATIONS AND VISITS WITH A GP OR NURSE	Out-of-hospital (rooms or home)	For your chosen GP: 100% of the lower of cost or Scheme Rate. R2 699 per beneficiary per year (on all) including minor procedures and consumables. For consultations with an out-of-area GP: First 3 consultations at 100% of the lower of cost or Scheme Rate. Fourth consultation onwards at 60% of the lower of cost or Scheme Rate.	M
ENDOSCOPIES	• Colonoscopy • Gastroscopy • Colonoscopy + Gastroscopy • Sigmoidoscopy	Day Hospital: 90% of Scheme Rate where applicable or 90% of lower cost or recommended tariff. In Rooms: 100% of Scheme Rate where applicable or 100% of lower cost or recommended tariff. Subject to Overall Annual Limit. See pg 19 for In-hospital.	
CONSULTATION AND VISITS WITH SPECIALISTS	Out-of-hospital (rooms or home)	If referred by GP: 80% of the lower of cost or Scheme Rate (including minor procedures and consumables) R2 699 per beneficiary per year. If not referred by GP: 60% of the lower of cost or Scheme Rate R2 629 per beneficiary per year.	M
DENTISTRY	Dental practitioners For basic dentistry; Oral Hygienist and Dental Therapists	80% of the lower of cost or Scheme Rate. M + 0 = R4 309 M + 1 = R7 111 M + 2 = R8 365 M + 3 = R9 596	M
	Advanced dentistry + Implants	No Benefit.	–
	Orthodontic treatment	No Benefit.	
	Oral Surgery, Maxillo-Facial Surgery: For consultations, visits, surgical procedures bu maxiillo facial specialists and dental practitioners	100% of the lower recommended tariff.	
MEDICINES, DEVICES AND INJECTION MATERIAL	Chronic medicines* as per Chronic Disease List (26 conditions covered)	100% of SEP including dispensing fee subject to use of SABMAS Pharmacy Network Provider. 20% co-payment for non-Network Provider. Reference pricing/MMAP applies.	M
	Prescribed acute medicines.	80% of the lower cost or determined of Acute medication programme+ dispensing fee charged. Further subject to the Overall Annual Limit. Acute Medicine Limit: M = R4 161 M + 1 = R6 827 M + 2 = R7 725 M + 3 = R8 478	M
	Contraceptives	Subject to the Overall Annual Limit, and further limited to R2 807 per female beneficiary per annum.	M
	Contraceptives devices + implants	80% of the lower cost or the price as determined by routine medication programme.	
	TTO after hospital event	Subject to the Acute Medicine Limit.	
	Pharmacy-advised therapy (PAT)/Over-the-counter medicines (OTC) ##	No Benefit.	–
	Chronis sickness conditions: Medicines other than anti-retroviral medication	100% of cost determined by the extended medication programme plus negotiated dispensing fee, for non-use of the DSP, a 20% co-payment will apply.	
	Homeopathic medicine	Subject to the Acute Medicine Limit.	
	Continuous blood glucose monitoring devices	Limited to R42 120 every 5 years. Subject to Scheme protocols and registration on the Diabetes Programme.	
	Immunisation and vaccines	80% of the lower cost of the price as determined by the routine medication programme plus the negotiated dispensing fee charged.	M
MENTAL HEALTH	Consults and procedures	R5 383 per family family. Subject to Overall Annual Limit. 100% consultation rate for GPs, psychologist and social workers and 80% for psychiatrist. Specialist referral rules apply. Registration on the mental health management programme.	M

ESSENTIAL 2025

BENEFITS	ESSENTIAL OPTION	ESSENTIAL MONETARY LIMIT R521 809 OVERALL ANNUAL LIMIT PER FAMILY (M)	
NON-SURGICAL PROCEDURES AND TESTS	Out-of-hospital (performed in doctor's rooms only)	100% of the lower of cost or commended tariff.	M
OPTICAL	Readers	100% of cost. R158 per beneficiary every 2 years.	M
	Frames and lens enhancements	100% of cost. R1 369 per beneficiary every 2 years.	M
	Spectacle lenses	Single vision lens - R242 per lens. Biofocal lens - R569 per lens. Multifocal lens - R1 053 per lens. Limited to one pair of lenses per beneficiary every 2 benefit years.	
	Contact lenses	No Benefit.	–
	Eye examinations	100% of the lower of cost or recommended tariff for eye examinations via a Network Optometrist. R432 per beneficiary per year. 1 Consultation per beneficiary per year.	M
	Refractive surgery	No Benefit.	
PATHOLOGY AND MEDICAL TECHNOLOGY	Pathology tests	Subject to Overall Annual Limit, 80% of the lower of costs or recommended tariff.	M
PHYSIOTHERAPY, BIOKINETICS AND CHIROPRACTORS	Physiotherapy and Biokinetics	80% of the lower of cost or recommended tariff R2 211 per family per year. No Benefit for Chiropractors.	M
	Back & Neck programme	Risk benefit, subject to registration on the back and neck programme and DSP usage and managed care protocols. Annual Benefit.	
RADIOLOGY AND RADIOGRAPHY	Basic Radiology including tests, scans and mammograms	Subject to Overall Annual Limit. 80% of the lower of the cost or recommended tariff.	M
	Specialised Radiology including In-and-Out-of-hospital (including magnetic resonance imaging (MRI), CT scans, angiography, bone densitometry and mammograms)	100% of the lower of cost or recommended tariff. Combined limit of R17 900 per family per year.	
REMEDIAL AND OTHER THERAPIES	Audiology, dietetics, hearing aid acoustics, occupational therapy, orthoptics, podiatry and speech therapy	80% of the lower of cost or recommended tariff. R2 481 per family collectively for all services.	
	Treatment and medicines prescribed or supplied for: Homeopathy, Naturopathy, Osteopathy	Homeopathic medication covered from acute if prescribed by a registered homeopath.	M
IN-HOSPITAL BENEFITS (SUBJECT TO OVERALL ANNUAL LIMIT)			
ALCOHOLISM AND DRUG DEPENDENCY*	For applicable services	100% of the lower of cost or recommended tariff for all services. 21 days at a SANCA facility or at SANCA rates per beneficiary; Subject to hospital benefit management programme and PMB regulations.	M
AMBULANCE SERVICES*	Emergency transport only (call 082 911)	100% of the lower of cost or recommended tariff. Subject to Overall Annual Limit.	M
MEDICAL AND SURGICAL APPLIANCES	Medical and surgical appliances including hearing aids	100% of the cost. R8 997 per family every 3 years.	M
	Hearing aids	100% of the cost. Once every three years, included in medical and surgical appliances limit.	
	Hearing aid repairs (including batteries)	100% of the cost. R3 763 per beneficiary once every 2 years.	M
	Home oxygen, cylinders, concentrators and ventilation expenses, excluding CPAP machines	100% of the lower of cost or recommended tariff. Subject to Overall Annual Limit.	M
BLOOD AND BLOOD PRODUCTS	Blood, blood equivalents and blood products	100% of the cost. Subject to Overall Annual Limit and hospital benefit management programme.	M
CONSULTATIONS AND VISITS	Out-of-hospital (general practitioners, specialists and nurse practitioners)	100% where a member uses their GP, where the member uses other GP other than selected, firs 3 consultations at 100% and 4th onwards at 60%. R2 629 per all services combined.	M
	Out-of-hospital (general practitioners, specialists and nurse practitioners)	100% of the lower of cost or Scheme Rate. Subject to Overall Annual Limit. R2 699 per benefitiary for services combined.	M
ENDOSCOPIES	• Colonoscopy • Gastroscopy • Colonoscopy + Gastroscopy • Sigmoidoscopy	100% of the lower of cost or recommended tariff In-hospital. Subject to Overall Annual Limit. In-Rooms see pg 18. Subject to hospital benefit management programme.	
DENTISTRY*	Osseo-integrated implants and Orthognatic surgery Orthodontic treatment	No Benefit.	–
	Oral Surgery and Maxillo-Facial Surgery	100% of the lower of cost or recommended tariff. Subject Overall Annual Limit and hospital benefit management programme.	M
HOSPITALISATION*	In patient (accommodation in general ward, high care ward and intensive care unit, theatre fees, medicines, materials, hospital equipment and transportation of blood)	100% of the lower of cost or Scheme Rate in an Acute Hospital Network facility. Subject to Overall Annual Limit.	M
	Outpatient (services and materials, excluding TTOs)	100% of the lower of cost as determined by the hospital benefit management programme.	M
	Alternatives to hospitalisation (step-down facility, private nursing and rehabilitation centres)	100% of the lower of the cost or recommended tariff. Subject to Overall Annual Limit.	M
	Compassionate Care Benefit for non-oncology patients (inpatient care and home nursing)	100% of the negotiated tariff. R54 565 per person per lifetime. Subject to Overall Annual Limit.	
	Hospital at Home	100% of the negotiated fee where applicable. Subject to Overall Annual Limit and hospital benefit management programme.	
IMMUNE DEFICIENCY RELATED TO HIV/AIDS*	Antiretroviral and related medicines All other services	100% of the cost, plus a fixed dispensing fee per line item where applicable. Subject to registration on the disease management programme.	M

ESSENTIAL 2025

BENEFITS	ESSENTIAL OPTION	ESSENTIAL MONETARY LIMIT	
MATERNITY*	Normal delivery: Hospitalisation (accommodation in a private or provincial hospital, theatre fees, labour ward fees, drugs, dressings, medicines and materials)	100% of the lower of cost or Scheme Rate. Register with the Maternity Management Programme.	M
	Caesarean section: Hospitalisation (accommodation in a private or provincial hospital, theatre fees, labour ward fees, drugs, dressings, medicines and materials)	100% of the lower of cost or Scheme Rate. Limited to R28 733 per confinement (limit may be exceeded for emergency/clinical reasons). Register on the Maternity Management Programme.	M
	Medical services and midwifery (antenatal consultations, pregnancy scans, tests, delivery services by a midwife)	100% of the lower of cost or Scheme Rate. 12 ante-natal visits, 2x 2D-scans per pregnancy. Subject to Overall Annual Limit and registration on the maternity programme.	M
MENTAL HEALTH*	Hospitalisation. Includes electro conclusive therapy fees, material and equipment (accommodation in a general ward).	100% of the lower cost or recommended tariff. R32 130 per beneficiary, including in-hospital consultations and procedures.	M
	In-hospital consultations, visits and procedures	Subject to and included in the limit of R33 993 for Mental Health - hospitalisation.	
NON-SURGICAL PROCEDURES AND TESTS*	In-hospital	100% of the lower of cost or Scheme Rate. Subject to Overall Annual Limit.	M
ONCOLOGY*	Consultations, visits, treatment, medicines and material used in radiotherapy and chemotherapy	All Oncology claims upto the amount of R250 000 per beneficiary for 12 months from the date of registration. There after PMB conditions will be funded at 80%.	M
OPTICAL	Refractive surgery ##	No Benefit.	–
ORGAN TRANSPLANTS*	Consultations, visits, harvesting and transplantation	100% of the negotiated fee applicable or 100% of lower cost or recommended tariff. R77 108 per family.	M
	Anti-rejection medicines	100% of lower cost. Subject to organ transplant limit.	M
PATHOLOGY AND MEDICAL TECHNOLOGY	In-hospital	100% of the lower of cost or recommended tariff. Subject to Overall Annual Limit.	M
PHYSIOTHERAPY, BIOKINETICS AND CHIROPRACTORS	In-hospital	100% of the lower of cost or recommended tariff. Subject to Overall Annual Limit.	M
PROSTHESES*	Internal and external	R75 079 per family No benefit for elective knee and hip replacement surgery. For PMB approved hip and knee prostheses, the Internal and External Prostheses limit will apply if a non-preferred supplier is used	M
RADIOLOGY AND RADIOGRAPHY*	Basic radiology	100% of the lower cost or recommended tariff. Subject to Overall Annual Limit	M
	Specialised radiology* (In-and-out-of-hospital (including magnetic resonance imaging (MRI), CT scans, angiography, bone densitometry and mammograms)	100% of the lower cost or recommended tariff. Limit of R17 900 per family per year. Subject to hospital benefit management programme.	M
RENAL DIALYSIS*	Acute and Chronic Renal Dialysis including specialists	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff. R69 081 per family.	M
SURGICAL PROCEDURES*	In-and-out-of-hospital	100% of the lower of cost or recommended tariff. Subject to Overall Annual Limit.	M
	Spinal care and surgery	100% Scheme rate or 100% of lower cost or recommended tariff. Subject to authorisation and treatment protocols. Subject to Overall Annual Limit.	M
	Circumcisions & Day Clinic procedures	Acute hospitals: 20% co-payment; Day hospital: 10% co-payment; Out-of-hospital: no co-payment. Subject to hospital benefit management programme and PMB regulations.	M
	Pre-Advanced Illness support	80% of lower cost or recommended tariff.	M

NOTE: This benefit summary is for information purposes only and does not supersede the Scheme Rules. In the event of any discrepancy between the summary and the Scheme Rules, the Rules will prevail.

YOUR BENEFIT OPTIONS

COMPREHENSIVE 2025

TREATMENT	COMPREHENSIVE OPTION	COMPREHENSIVE MONETARY LIMIT	
OUT-OF-HOSPITAL BENEFITS			
ROUTINE		Benefits are subject to the following routine benefit limits (R) and category sub-limits. M + 0 = R26 872 M + 1 = R35 929 M + 2 = R43 087 M + 3 = R48 632 Member liable for a co-payment where applicable.	
ALTERNATIVE HEALTHCARE SERVICES	Acupuncture, Naturopathy and Osteopathy	80% of the lower of cost or recommended tariff. Subject to Day-to-Day limit.	R
CONSULTATIONS AND VISITS WITH A GP OR NURSE	Out-of-hospital (rooms or home)	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff. R5 948 per beneficiary for all services combined, including surgical procedures and consumables.	R
CONSULTATIONS AND VISITS WITH SPECIALISTS	Out-of-hospital (rooms or home)	If referred by GP: 80% of the lower of cost or Scheme Rate, where member is not referred by a GP 60% of lower cost or recommended tariff.	M
ENDOSCOPIES	• Colonoscopy • Gastroscopy • Colonoscopy + Gastroscopy • Sigmoidoscopy	Day Hospital: 80% of Scheme Rate where applicable or 80% of lower cost or recommended tariff. In Rooms: 100% of Scheme Rate where applicable or 100% of lower cost or recommended tariff. Unlimited. In-hospital benefit see page 22.	
BASIC DENTISTRY	Dental practitioners For basic dentistry; Oral Hygienist and Dental Therapists	80% of lower cost or recommended tariffs. Subject to Day-to-Day limit upfront payment for Basic Dentistry performed In Hospital / Day Clinic: 12 years and younger: R2 936 In-Hospital/R1 329 Day Clinic. 13 years and older: R7 533 In-Hospital/R4 819 in Day Clinic.	R
	Advanced dentistry	80% of lower cost or Scheme Rate. M + 0 = R13 436 M + 1 = R17 578	M
	Orthodontic treatment	100% of lower cost or Scheme Rate. Subject to and included in Advanced Dentistry Limit and prior scheme approval.	
MEDICINES AND INJECTION MATERIAL	Chronic medicines* as per Chronic Disease List (26 conditions covered plus additional 28 non CDL conditions listed.)	100% of the cost determined by the extended or chronic medication programme plus the negotiated dispensing fee charged at a Scheme DSP. Subject to the extended chronic medication programme.	
	Prescribed acute medicine	80% of lower cost or the price as determined by routine medication programme plus the negotiated dispensing fee charged. Subject to Day-to-Day limit.	M
	Contraceptives	Limit of R2 820 per female beneficiary per annum.	R
	Contraceptive Devices and Implants	80% of the lower cost or the price as per determined by the routine medication programme. Limited to frequency of the device.	R
	TTO after hospital event	Subject to the Day-to-Day limit.	
	Pharmacy assisted therapy	100% of cost. Subject to available savings.	MSA
	Immunisation and vaccines	80% of lower cost or the price as determined by routine medication programme plus the negotiated dispensing fee charged. Subject to Day-to-Day limit.	R
	Homeopathic medicine	Subject to the Day-to-Day limit.	
MENTAL HEALTH	Consults and procedures	100% of Scheme Rate and psychiatric consultation is 80%. Specialist rules apply. Subject to PMB and treatment guidelines and managed care criteria. R16 174 per family.	M
NON-SURGICAL PROCEDURES AND TESTS	Out-of-hospital (performed in doctor's rooms only)	100% of the lower cost or recommended tariff. Unlimited. Subject to hospital benefit and disease risk management programmes.	M
OPTICAL	Readers	100% of cost. R211 per beneficiary every 2 years.	R
	Frames and Lens enhancements	100% of cost. R2 317 per beneficiary every 2 years.	R
	Prescribed spectacle lenses	Single vision lens - R242 per lens. Bifocal lens - R569 per lens. Multifocal lens - R1053 per lens. Limited to one pair of lenses per beneficiary every 2 benefit years.	
	Contact lenses	R3 370 per beneficiary per benefit year	R
	Eye examinations	100% of the lower of cost or recommended tariff for eye examinations. Scheme Rate of R548.	R

COMPREHENSIVE 2025

TREATMENT	COMPREHENSIVE OPTION	COMPREHENSIVE MONETARY LIMIT	
PATHOLOGY AND MEDICAL TECHNOLOGY	Pathology	Subject to Day-to-Day limit. 80% of the lower of cost or recommended tariff.	R
PHYSIOTHERAPY, BIOKINETICS AND CHIROPRACTORS	Out-of-hospital. (No benefit for Chiropractors)	Registered on the programme: 100% of lower cost or recommended tariff. Not registered: 80%of lower cost or recommended tariff. Overall Annual Limit.	R
RADIOLOGY AND RADIOGRAPHY	Out-of-hospital Basic Radiology	80% of lower cost or recommended tariff. Subject to Day-to-Day limit.	R
	Specialised radiology CT scan, MRI, etc (In-and-Out-of-hospital (including magnetic resonance imaging (MRI), CT scans, angiography, bone densitometry and mammograms	100% of the lower of cost or recommended tariff. Combined limit of R26 430 per family.	
REMEDIAL AND OTHER THERAPIES	Audiology, dietetics, hearing aid acoustics, occupational therapy, orthoptics, podiatry and speech therapy	80% of lower cost or recommended tariff. Subject to Day-to-Day limit.	
	Alternative Healthcare Services Treatment and medicines prescribed or supplied for: Homeopathy, Naturopathy, Osteopathy	80% of the lower cost or recommended tariff. Subject to the Day-to-Day limit.	R
IN-HOSPITAL BENEFITS			
ALCOHOLISM AND DRUG DEPENDENCY*	For applicable services	100% of the lower of cost or recommended tariff for all services. 21 days at a SANCA facility or at SANCA rates per beneficiary; Subject to PMB limits.	M
AMBULANCE SERVICES*	Emergency transport only (call 082 911)	100% of the lower of cost or recommended tariff. Unlimited, subject to conditions, limits and PMB regulations.	M
MEDICAL AND SURGICAL APPLIANCES	Medical and surgical appliances including hearing aids	100% of the cost. R21 530 per family.	M
	Hearing aids	Once every 3 years, included in medical and surgical appliances limit.	
	Hearing aid repairs (including batteries)	R3 763 per beneficiary once every 2 years.	M
	Home oxygen, cylinders, concentrators and ventilation expenses, excluding CPAP machines	Unlimited.	M
BLOOD AND BLOOD PRODUCTS	Blood, blood equivalents and blood products	Unlimited.	M
CONSULTATIONS AND VISITS	In-hospital (general practitioners, specialists and nurse practitioners)	100% Scheme Rate or 100% of lower cost or recommended tariff. Unlimited. Subject to hospital benefit management programme and PMB regulations.	M
ENDOSCOPIES	• Colonoscopy • Gastroscopy • Colonoscopy + Gastroscopy • Sigmoidoscopy	100% Scheme rate Unlimited. Day clinic and In-Rooms see pg.21. Subject to hospital benefit management programme and PMB regulations.	
ADVANCED DENTISTRY*	Osseo-integrated implants and orthognatic surgery (including the cost of hospitalisation, dental practitioners, anaesthetist fees and implants)	Subject to and included in Advanced Dentistry limit and dentistry benefit management programme.	M
	Oral Surgery and Maxillo-Facial Surgery	Unlimited. Subject to hospital benefit management programme.	M
HOSPITALISATION*	In patient (accommodation in general ward, high care ward and intensive care unit, theatre fees, medicines, materials, hospital equipment and transportation of blood)	100% of the lower of cost or recommended tariff. Unlimited. Subject to hospital benefit management programme.	M
	Outpatient (services and materials, excluding TTOs)	80% of the lower of cost. Subject to hospital benefit management programme conditions and Day-to-Day and Overall Annual limits.	M
	Alternatives to hospitalisation (step-down facility and private nursing)	Unlimited. Subject to hospital benefit management programme conditions and limits.	M
	Step-down facilities	Unlimited. Subject to hospital benefit management programme conditions and limits.	M
	Private hospital rehabilitation services	R107 555 per family. Subject to hospital benefit management programme and PMB benefits.	
	Compationate Care for non-oncology patients (Inpatient care and home nursing)	R76 891 per person per lifetime. Subject to PMB benefits.	
	Hospital at Home	100% of the negotiated fee where applicable. Subject to Overall Annual Limit and hospital benefit management programme.	
IMMUNE DEFICIENCY RELATED TO HIV/AIDS*	Antiretroviral and related medicines All other services	100% of the cost, plus a fixed dispensing fee per line item where applicable. Unlimited. Subject to registering on the chronic medication programme.	M
MATERNITY*	Normal delivery: Hospitalisation (accommodation in a private or provincial hospital, theatre fees, labour ward fees, drugs, dressings, medicines and materials)	100% of the lower of cost or Scheme Rate. Register with the Maternity Management Programme.	M
	Caesarean section: Hospitalisation (accommodation in a private or provincial hospital, theatre fees, labour ward fees, drugs, dressings, medicines and materials)	100% of the lower of cost or Scheme Rate Register with the Maternity Management Programme.	M
	Medical services and midwifery (antenatal consultations, pregnancy scans, tests, delivery services by a midwife)	100% of the lower of cost or Scheme Rate. 12x antenatal visits and 2x2D-scans per pregnancy, subject to registration on the maternity programme.	M
MENTAL HEALTH*	Hospitalisation (accommodation in a general ward, electro convulsive therapy (ECT), medicines, materials and hospital equipment)	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. R50 047 per beneficiary. Subject to PMB.	M
	In-hospital consultations, visits and procedures	100% of the lower of cost or Scheme Rate. Unlimited.	M

COMPREHENSIVE 2025

TREATMENT	COMPREHENSIVE OPTION	COMPREHENSIVE MONETARY LIMIT	
NON-SURGICAL PROCEDURES AND TESTS*	In-hospital	100% of the lower cost or recommended tariff. Unlimited. Subject to hospital benefit management programme conditions and limits.	M
ONCOLOGY*	Consultations, visits, treatment, medicines and material used in radiotherapy/chemotherapy	All Oncology claims upto the amount of R500 000 per beneficiary for 12 months from the date of registration. There after PMB conditions will be funded at 80%.	M
OPTICAL	Refractive surgery##	100% of the negotiated fee where applicable or 100% of the lower of cost between the negotiated fees and recommended tariff. R11 939 per beneficiary per life time. Subject to clinical protocols.	M
ORGAN TRANSPLANTS*	Consultations, visits, harvesting and transplantation	Unlimited. Subject to hospital benefit and disease risk management programmes conditions and limits.	M
	Anti-rejection medicines	100% of the cost determined by the chronic medication programme.	M
PATHOLOGY AND MEDICAL TECHNOLOGY	In-hospital	Unlimited. Subject to hospital benefit management programme conditions and limits.	M
PHYSIOTHERAPY, BIOKINETICS AND CHIROPRACTORS	In-hospital Back and Neck programme	Unlimited Annual Benefit. Subject to registration on back and neck programme and DSP usage and manged care protocols.	M
PROSTHESES*	Internal and external	100% of cost. R90 004 per family.	M
RADIOLOGY AND RADIOGRAPHY*	Basic radiology: In-hospital diagnostic radiology tests and scans	Unlimited.	M
	Specialised radiology*: In-and-out-of-hospital (including magnetic resonance imaging (MRI), CT scans, angiography, bone densitometry and mammograms)	100% of the lower of cost or recommended tariff. Combined limit of R26 430 per family.	M
RENAL DIALYSIS*	Acute and chronic (consultations, visits, associated services and materials)	Unlimited. Subject to hospital benefit management programme conditions and limits and PMB regulations.	M
SURGICAL PROCEDURES*	In-and-out-of-hospital	100% of the lower or recommended tariff. Unlimited. Subject to hospital benefit management programme and disease management programme.	M
	Spinal care and surgery	100% Scheme rate or 100% of lower cost or recommended tariff. Subject to authorisation and treatment protocols.	
	Circumcisions & Day Clinic procedure	Acute hospitals: 20% co-payment; Day Hospital: 10% co-payment; out-of-hospital: no co-payment. Subject to hospital benefit management programme and PMB regulations.	
	Pre-Advanced Illness support	80% of lower cost or recommended tariff.	

* Benefits denoted by an asterisk are subject to authorisation

Denotes benefits which are only available on the Comprehensive option

Glossary

DSP: Designated Service Provider
M: Major Medical Benefit
MMAP: Maximum Medical Aid Pricing
MSA: Medical Savings Account
OAL: Overall Annual Limit
SCHEME RATE: Negotiated Rate
SEP: Single Exit Price
TTO: To take home medication

Visit www.sabmas.co.za and select Doctor Visits and then Find a Healthcare Provider to find a network pharmacy nearest to you.

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CONTRIBUTIONS FOR 2025

BASIC MONTHLY INCOME (R)	ESSENTIAL OPTION TOTAL MONTHLY CONTRIBUTION, INCLUDING SAVINGS			COMPREHENSIVE OPTION TOTAL MONTHLY CONTRIBUTION (INCLUDES 10% SAVINGS)		
	MEMBER	ADULT DEPENDANT OVER 21	CHILD DEPENDANT UNDER 21	MAIN MEMBER	ADULT	CHILD
0 -- 6 900	R1 595	R1 595	R476	R3 797	R3 797	R1 139
6 901 - 10 600	R1 873	R1 873	R559	R4 066	R4 066	R1 224
10 601 – 14 100	R1 927	R1 927	R574	R4 152	R4 152	R1 247
14 101 – 17 600	R1 990	R1 990	R599	R4 235	R4 235	R1 268
17 601 – 21 100	R2 052	R2 052	R614	R4 321	R4 321	R1 304
21 101 – 24 600	R2 118	R2 118	R636	R4 419	R4 419	R1 322
24 601 – 28 200	R2 203	R2 203	R659	R4 505	R4 505	R1 353
28 201 – 35 300	R2 284	R2 284	R687	R4 599	R4 599	R1 377
35 301 – 42 100	R2 363	R2 363	R714	R4 680	R4 680	R1 400
42 101 – 48 500	R2 449	R2 449	R736	R4 768	R4 768	R1 428
48 501 – 55 000	R2 523	R2 523	R757	R4 865	R4 865	R1 454
55 001+	R2 598	R2 598	R781	R4 963	R4 963	R1 484

THE WELLNESS BENEFIT

What we cover as part of the Wellness Benefit

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 the 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)

Know your health status – we cover 100% of the Scheme Rate for a variety of health checks.

WHAT PROGRAMMES	WHAT DO THE PROGRAMMES COVER?	WHICH AGES ARE COVERED?	HOW OFTEN ARE BENEFITS ALLOWED?	HOW MUCH DO WE COVER?
IMMUNISATION PROGRAMMES	Child Immunisations	As per the Department of Health's recommended immunisation programme.	In line with Department of Health guidelines.	100% of the lower of cost or recommended tariff.
	Tetanus Booster	As required	As required	100% of the lower of cost or recommended tariff.
	Influenza Vaccination	All beneficiaries	One every year	100% of the lower of cost or recommended tariff.
	Pneumococcal Vaccination	60+ years old and high-risk individuals	One every year	100% of the lower of cost or recommended tariff.
	HPV Vaccination	Age: 9 - 24 years	(2 doses) Once	100% of the lower of cost or recommended tariff.
EARLY DETECTION PROGRAMMES	Full General Physical Examination		Subject to the GPs, Specialists and Nurses consultation limit.	100% of the lower of cost or recommended tariff.
	Mammogram	Females aged 40 years and older. For high-risk females aged 40 years and younger on motivation.	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 mammogram result and require a sonar procedure to assist with further diagnosis.

WHAT PROGRAMMES	WHAT DO THE PROGRAMMES COVER?	WHICH AGES ARE COVERED?	HOW OFTEN ARE BENEFITS ALLOWED?	HOW MUCH DO WE COVER?
	Prostate-Specific Antigen Test	Males 40-49 years old	Once every five years	100% of the lower of cost or recommended tariff.
		Males 50-59 years old	Once every three years	100% of the lower of cost or recommended tariff.
		Males 60-69 years old	One every two years	100% of the lower of cost or recommended tariff.
		Males 70+ years old	Once a year	100% of the lower of cost or recommended tariff.
	DEXA Scan	50+ males and females	One every 3 years	100% of the lower of cost or recommended tariff.
	Health Assessment Tests: ▪ BMI (Body Mass Index) ▪ Blood Sugar Test ▪ Blood Pressure Test ▪ Cholesterol Test	All adults	One every year, as indicated	100% of the lower of cost or recommended tariff.
	Cholesterol Blood Test		1 per year	100% of the lower of cost or recommended tariff.
	Blood Sugar Blood Test		1 per year	100% of the lower of cost or recommended tariff.
	HIV test and HIV finger prick test	Male and female	One every year, additional tests will be paid from Day-to-Day benefits	100% of the lower of cost or recommended tariff.

WHAT PROGRAMMES ARE COVERED?	WHAT DO THE PROGRAMMES COVER?	WHICH AGES ARE COVERED?	HOW OFTEN ARE BENEFITS ALLOWED?	HOW MUCH DO WE COVER?
EARLY DETECTION PROGRAMMES (continued)	Pap Smear	Female	Consultation subject to Day-to-Day limit. Cytology one every 3 years HPV test one every 5 years	100% of the lower of cost or recommended tariff
	Glaucoma Test	Adults 40+	40-49 years: once every 2 years 50+ years: once a year	100% of the lower of cost or recommended tariff
	Dentistry: General full mouth examination by a general dentist or oral hygienist (including sterile tray and gloves), plus polishing and scaling.		One every year	100% of the lower of cost or recommended tariff
	Maternity **REGISTRATION ON THE MATERNITY MANAGEMENT PROGRAMME IS COMPULSORY**	Antiglobulin Test (Coombs)	One test per female beneficiary per pregnancy	100% of the lower of cost or recommended tariff
		HIV Antibody/ELISA	At least two tests per female beneficiary per pregnancy	100% of the lower of cost or recommended tariff
		Full Blood Count	One test per female beneficiary per pregnancy	100% of the lower of cost or recommended tariff
		Grouping: Rh Antigen	One test per female beneficiary per pregnancy	100% of the lower of cost or recommended tariff
		Rubella-IgM: Specific Antibody Titer: ELISE/EMIT per Ag	One test per female beneficiary per pregnancy	100% of the lower of cost or recommended tariff
		Quantitative Khan VDLR or other Flocculation (TPHA)	One test per female beneficiary per pregnancy	100% of the lower of cost or recommended tariff
		Beta HCG Qualitative &/or Quantitative	One test per female beneficiary per pregnancy	100% of the lower of cost or recommended tariff
		Hepatitis B H306 Surface Antigen	One test per female beneficiary per pregnancy	100% of the lower of cost or recommended tariff
	Colon Cancer Faecal Occult Blood Test		One every 2 years	100% of the lower of cost or recommended tariff

WHAT PROGRAMMES ARE COVERED?	WHAT DO THE PROGRAMMES COVER?	WHICH AGES ARE COVERED?	HOW OFTEN ARE BENEFITS ALLOWED?	HOW MUCH DO WE COVER?
World Health Organisation (WHO) Global Outbreak Benefit	Basket of care which includes In-Hospital and Out-of-Hospital management and supportive treatment of global World Health Organisation recognised disease outbreaks	COVID-19 Monkeypox	In-Hospital: Unlimited Out-of-Hospital: Subject to Day-to-Day limit	100% of the lower of cost or recommended tariff for services within the basket of care.

NOTE: As a member, either on the Comprehensive or Essential Plan, you automatically qualify for this Wellness Benefit.

Registration on the maternity plan is compulsory.

DAY CLINIC PROCEDURES:

ESSENTIAL

Ear, Nose & Throat Surgery (ENT)
- Tonsillectomy
- Laryngoscopy
- Eustachian tube dilatation
- Intranasal antrostomies
- Bronchoscopy
- Myringotomy with grommet insertion

Ophthalmology
- Cataracts GI / local block
- Pterygium
- Evisceration of eye
- Vitrectomy
- Phacoemulsification
- Posterior vitrectomy and PPV

Gynaecology
- Cauterization of vaginal warts
- Dilatation & curetation
- LLETZ biopsy colposcopy
- Hysteroscopy
- Cyst excision

Urology
- Circumcision
- Prostate biopsy
- Vasectomy
- Brachytherapy
- Cystoscopy and bladder biopsy
- Ureteroscopy

General Surgery
- Skin lesion repairs
- Excision of melanoma
- Ingrown toenail removal
- Sebaceous cyst excision
- Haemorrhoidectomy
- Incision and drainage of abscess
- Proctoscopy

Orthopaedic Surgery
- Arthroscopy shoulder, knee, elbow, wrist & ankle
- Dupuytren's
- Prosthesis/external fixators removal
- Trigger finger release

Dental procedures
- Extractions
- Fillings
- Polishing
- Pulpotomies
- Root canals

Maxillo facial procedures
- Impacted teeth (excluding Wisdoms)

Neurosurgery
- Facet blocks
- Infiltrations
- Rhizotomies

COMPREHENSIVE

Ear, Nose & Throat Surgery (ENT)
- Tonsillectomy
- Laryngoscopy
- Eustachian tube dilatation
- Intranasal antrostomies
- Bronchoscopy
- Myringotomy with grommet insertion

Ophthalmology
- Cataracts GI / local block
- Pterygium
- Evisceration of eye
- Vitrectomy
- Phacoemulsification
- Posterior vitrectomy and PPV

Gynaecology
- Cauterization of vaginal warts
- Dilatation & curetation
- LLETZ biopsy colposcopy
- Hysteroscopy
- Cyst excision

Urology
- Circumcision
- Prostate biopsy
- Vasectomy
- Brachytherapy
- Cystoscopy and bladder biopsy
- Ureteroscopy

OTHER AREAS **WE HELP WITH**

MATERNITY MANAGEMENT PROGRAMME

We care about your little ones, even before they're born. This is why our Maternity Management Programme is there to assist you during pregnancy. Benefit from pre-natal healthcare, including advice tailored to the stage in your pregnancy. You will be entitled to 12 antenatal visits, 2x 2-D scans. blood tests, pregnancy vitamins, maternity support programme, including maternity bag as set out in page 27.

Important:

You need to register on the Maternity Management Programme as soon as your pregnancy has been confirmed.
Twelve-week-scan time? Contact us on 0860 002 133. Please keep in mind that if you don't join this programme, you'll have to pay for the gynaecologist consultations and your two scans out of your Day-to-Day Benefits – this will make it run out quicker. Wouldn't you rather save that money for a new pram or a car seat?

OUT-OF-HOSPITAL DTP PMB (DIAGNOSED TREATMENT PAIR PRESCRIBED MINIMUM BENEFIT)

The Scheme pays for specific healthcare services related to each of your approved conditions. These services include treatment, acute medicine, consultations, blood tests and other investigative tests. We cover kidney, heart or liver treatment relating to transplants as a Prescribed Minimum Benefit (PMB).

If you want to apply for cover under Prescribed Minimum Benefits for treatment of a condition without hospital admission, you must complete a Prescribed Minimum Benefit form.

ONCOLOGY MANAGEMENT PROGRAMME

Members registered on the Oncology Management Programme have access to an oncology ancillary basket. This basket includes items that are not necessarily part of your direct treatment, but that will assist with your care during treatment, for example, anti-nausea medications following chemotherapy.

The basket also consists of a list of all the consultations, radiology and pathology available to you.

All of the items within the ancillary basket will be paid from your Oncology Benefit, as long as the correct ICD-10 code is used. These baskets are allocated based on defined protocols.

If you need any treatment that does not form part of the oncology PMB ancillary basket or if you have used up certain items within the basket, your Healthcare Provider must contact us to motivate for extended cover.

The Scheme will cover the costs of your oncology treatment at 100% of the Scheme Rate, up to a threshold. Once this threshold has been reached, the Scheme will continue cover at 80% of the Scheme Rate. Once the Oncology Benefit threshold is depleted, approved Oncology PMB treatment will fund at 100% of the scheme rate.

To register on the Oncology Programme, please ask your Healthcare Provider to send through the histology report confirming the cancer to **oncology@sabmas.co.za.** Alternatively, you can contact us on **0860 002 133.**

COMPASSIONATE CARE

The Compassionate Care Benefit gives you access to holistic home-based end-of-life care per person in their lifetime.

ADVANCED ILLNESS BENEFIT (AIB) AND MEMBER SUPPORT PROGRAMME

Members with cancer have access to a comprehensive palliative care programme. This programme offers unlimited cover for approved care at home.

The advanced illness member support programme is a pre-AIB benefit, with access to providers specializing in palliation. This allows members to establish relationships and create a link to support and maintain their wellbeing until such time that they may require AIB benefits.

AID FOR AIDS PROGRAMME

Aid for AIDS, our HIV management programme, offers members and dependants:

- Medicine to treat HIV* and vitamins to boost the immune system
- Regular monitoring of the condition
- Monitoring of the patient's response to therapy
- Monitoring tests to detect side effects
- Ongoing patient support via dedicated counsellors
- Assistance in finding a registered counsellor for emotional support.

* This includes medicine to prevent mother-to-child transmission and infection after sexual assault or needle-stick injury.

If a test confirms that you are HIV positive, you must register with Aid for AIDS as soon as possible. Aid for AIDS will keep your status confidential. Contact them on **0860 100 646** and request an application form, or ask your Healthcare Provider to call them on your behalf.

To register, please visit: www.aidforaids.co.za or send a confidential text message to 083 410 9078.

If you are exposed to HIV through sexual assault or from a needle or injection, please ask your doctor to call Aid for AIDS urgently. We can authorise Post Exposure Prophylaxis (PEP) Antiretroviral medicine and we can help you prevent possible HIV infection with Pre Exposure Prophylaxis (PrEP).

NETCARE 911 ON 082 911

If the unthinkable happens and you're faced with a medical emergency like a car accident or a heart attack, there's only one number you must remember: **082 911**. (Don't wait. Put

it into your cellphone and your loved ones' cellphones now!).

Not only is Netcare 911 South Africa's favourite provider of emergency medical services, it has several benefits:

- They ensure great response times
- They ensure the correct emergency staff is sent to a medical emergency to provide the correct level of care
- Invoices are sent directly to Netcare 911, so you don't have to worry about receiving and submitting them.

Another important benefit of Netcare 911 is that you have access to free telephonic advice from registered nurses and telephonic trauma assistance by qualified trauma counsellors. We encourage you to use this benefit. It's available 24/7.

Remember, in an emergency call **082 911.**

DID YOU KNOW?

Netcare 911 has over 200 emergency vehicles as well as a fleet of fixed-wing and helicopter air ambulances.

TREATMENT BASKETS FOR THE PRESCRIBED MINIMUM BENEFIT (PMB) CHRONIC DISEASE (CDL) CONDITIONS

The Prescribed Minimum Benefit Chronic Disease List is a list of conditions which all medical schemes need to cover on all the Options they offer to their members. This cover includes funding for the diagnosis, treatment and ongoing care of the listed conditions.

We will only pay Prescribed Minimum Benefit claims if cover for your condition has been approved on the Chronic Medicine Benefit. Only claims for procedures and consultations listed in the Prescribed Minimum Benefit (PMB) treatment Baskets will be paid from the Chronic Disease Basket of Care.

We will pay for tests and procedures for your condition according to the treatment baskets. We pay for certain tests like blood tests and X-rays according to the PMB treatment Baskets. This cover includes tests and procedures for both the diagnosis and ongoing management for each of the PMB Chronic Disease List conditions. We pay for listed blood tests, scans and X-rays up to a maximum of the Scheme Rate.

We will not pay claims from the Chronic Disease Basket of Care in the following instances

- The claims are submitted without the relevant ICD-10 codes
- You are not yet registered on the Chronic Disease Programme for the specific PMB condition
- When you have exceeded the frequncy limit, then the Day-to-Day benefit will be utilised if there are funds available.

To find a doctor who is a Network Provider, please use the Find a HealthCare Professional tool on www.sabmas.co.za.

BENEFIT EXCLUSIONS

Like most medical schemes, we don't cover costs related to treating obesity, self-inflicted injuries, injuries resulting from professional sport and holidays for healing purposes. While we cover dental procedures, we don't cover dental treatment under general anaesthetic or conscious sedation, once the patient is older than eight years. We also don't cover cosmetic procedures like certain plastic, reconstructive surgeries or dental implants.

Look at the Scheme Rules at www.sabmas.co.za, or see below for the list of exclusions:

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 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.

2. LIMITATION OF BENEFITS

2.1 In cases of illness of a protracted nature, the Board shall have the right to insist upon a member or dependant of a member consulting any particular specialist the Board may nominate in consultation with the attending practitioner. In such cases, if the specialist's advice is not acted upon, no further benefits will be allowed for that particular illness.

2.2 The Board may require a second opinion in respect of any claim for benefits and for that purpose the relevant beneficiary shall consult a dental or medical practitioner nominated by the Board and at the cost of the Scheme. In the event that the beneficiary refuses or neglects to comply with the requirement of the Board, no benefits will be allowed for that particular claim.

2.3 Unless otherwise decided by the Board, 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.

3. BENEFITS EXCLUDED

Unless otherwise decided by the Board (and with the express exception of medicines or treatment approved and authorised in terms of the routine medication, extended or chronic medication, hospital benefit management and disease management programmes), expenses incurred in connection with any of the following will not be paid by the Scheme:

(All items marked with an asterisk (*) may be paid at 100% of cost from the member's savings account on the Comprehensive option, except for prescribed minimum benefits, which may not be funded from savings)

*3.1 all costs incurred for the prevention and treatment of obesity;

*3.2 all costs for operations, medicines, treatments, and procedures for cosmetic purposes or for personal reasons and not directly caused by or related to illness, accident, or disease, including:
*3.2.1 abdominoplasties (including the repair of divarication of the abdominal muscles);
*3.2.2 bilateral gynecomastia on Essential Option;
*3.2.3 blepharoplasties;
*3.2.4 breast augmentation; unless medically necessary
*3.2.5 breast reconstruction (unless mastectomy is pre-authorised) with medical reasons
*3.2.6 breast reductions on Essential Option, unless medically necessary
*3.2.7 genioplasties based on protocols
*3.2.8 hirsutism, except for prescribed minimum benefits as per regulation 8 of the Act;
*3.2.9 keloid surgery, except for prescribed minimum benefits as per regulation 8 of the Act;
*3.2.10 otoplasties;
*3.2.11 refractive surgery on Essential Option;
*3.2.12 revision of scars;
*3.2.13 rhinoplasties

3.3 all costs related to wilfully self-inflicted injuries or conditions except for PMBs;

*3.4 the artificial insemination of a person as defined in the Human Tissue Act, 1983 (Act 65 of 1983);

*3.5 all costs in respect of injuries arising from professional sport, speed contests and speed trials; except for PMB's;

*3.6 all costs that are more than the annual maximum benefit to which a member is entitled in terms of the rules, unless otherwise agreed by the Board in terms of the rules; except for PMB's;

3.7 all costs of whatsoever nature incurred for treatment of sickness conditions sustained by a member or a dependant and for which any other party is liable. The member is, however entitled to such benefit as would have applied under normal conditions, provided that should any amount be recovered from the other party, that amount shall first be applied to offset the medical expenses met by the Scheme. In order to access benefits where another party may be proven to be liable, the Principal Member will be required to undertake to repay the Scheme in accordance with this provision. In cases where the sickness or injury is a prescribed minimum benefit condition, the claim must be paid in full by the medical scheme within 30 days and the funds can be recuperated afterwards.

3.8 The purchase of medicines not included in a prescription from a medical practitioner; except for over the counter (OTC) medicines, subject to the limit applied by the scheme

3.9 all costs for services rendered by:
3.9.1 persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or
3.9.2 any institution, nursing home or similar institution, except a state or provincial hospital, not registered in terms of any law; provided that, if in terms of the rules, a member incurs a cost for services rendered outside the Republic of South Africa for which, in the discretion of the Board a benefit would have been payable if such service had been rendered within the Republic of South Africa, such service shall be deemed to have been rendered in the Republic of South Africa, but paid at the applicable rate and subject to any limitations that would normally apply to an equivalent non-PMB claim within the borders of South Africa (PMB regulations do not apply to foreign claims);

3.10 All costs related to the purchase, provision or treatment of the following except for PMBs:
*3.10.1 Preparations used specifically to treat and/or prevent obesity);
*3.10.2 Household remedies or preparations of the type generally promoted to the public to increase consumption;
*3.10.3 Nutritional supplements including baby food and special formulae;
*3.10.4 Medicines used specifically to promote fertility;
*3.10.5 Medicines used specifically to treat alcoholism;
*3.10.6 Household type bandages and dressings;
*3.10.7 Aphrodisiacs;
*3.10.8 Soaps, shampoos, and other topical applications; medicated or otherwise;
*3.10.9 Topical sun screening, sun tanning and after sun agents;
*3.10.10 Preparations to treat a smoking habit;
*3.10.11 Biological vaccines (oral and parenteral) except those included in the benefits;
*3.10.12 Anabolic steroids;
*3.10.13 Multivitamin preparations and vitamin combinations;
*3.10.14 Single or combined mineral preparations;
*3.10.15 Contact lens preparations;
*3.10.16 Cosmetic preparations medicated or otherwise;
*3.10.17 Prenatal and infant vitamins and vitamin/mineral supplements;
*3.10.18 Geriatric vitamins and vitamins, mineral supplements;
*3.10.19 Single vitamin preparations;
*3.10.20
*3.10.21 Immune sera and immunoglobulins;
*3.10.22 Allergens;
*3.10.23 Haematinics unless prescribed;
*3.10.24 Topical acne preparations;
*3.10.25 Single calcium preparations;
*3.10.26 Essential fatty acid preparations and combinations;
*3.10.27 Tonics and stimulants;
*3.10.28 Non-specific/non-recoverable/involuntary withdrawn Products i.e. products with non-specific NAPPI codes include NAPPI codes that have been assigned for use for multiple products where the exact products are not defined, and a specific costing cannot be allocated;
*3.10.29 Voluntary withdrawn products i.e., products that have been withdrawn by companies out of their own free will;
*3.10.30 Section 21 products;
*3.10.31 Over-the-counter reading glasses;
*3.10.32 Professional services by pharmacists, excluding screening test
*3.10.33 All costs for genetic testing

3.11 all costs for accommodation and services provided in a geriatric hospital, old age home or the like;

3.12 holidays for recuperative purposes;

3.13 charges for appointments which a member or dependant of a member fails to keep;

3.14 all costs for 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 prostheses;

3.15 all optical devices which are not regarded by the Optometric Benefit Management Programme as clinically essential or clinically desirable including tinting, extra-large blanks, sunglasses and repairs to frames and lenses;

3.16 anaesthetics:
3.16.1 in respect of dental services:
3.16.1.1 general anaesthetics, conscious sedation, and hospitalisation for dental work except in the case of trauma, patients under the age of 8 years and bony impaction of third molars;
13.16.1.2 all general anaesthetics and conscious sedation in the practitioners' rooms unless pre-authorised;
3.16.2 in respect of all medical services: all general anaesthetics and conscious sedation in the practitioners' rooms unless pre-authorised;

3.17 no claim shall be payable by the Scheme if, in the opinion of the medical adviser, the health care service in respect of which such claim is made, is not appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition at an affordable level of service and cost;

3.18 all costs for treatment if its efficacy and safety cannot be proved to the satisfaction of the medical adviser or have not been published in scientific peer-reviewed journals or in standard medical texts or treatment which in the opinion of the medical adviser is not affordable from an individual and Scheme healthcare perspective; the onus being on the treating medical or dental practitioner to provide the necessary documentary evidence;

3.19 all costs for traveling expenses incurred by a member or a dependant, except for ambulance services provided for elsewhere in these rules;

3.20 all costs related to the treatment of erectile dysfunction and loss of libido;

3.21 all costs related to gender re-alignment for personal reasons and not directly caused by or related to illness, accident, or disease;

3.22 new medicines until their cost-effectiveness, affordability and evidence-based role in drug therapy have been established;

3.23 all costs for devices, appliances, and procedures not scientifically proven or appropriate or affordable from a Scheme healthcare perspective;

3.24 all costs for orthodontic treatment in respect of beneficiaries over the age of 21 years;

3.25 all costs for labial frenectomies in respect of beneficiaries under the age of 12 years;

3.26 all costs for photodynamic therapy for macular degeneration, except for prescribed minimum benefits as per regulation 8 of the Act;

3.27 all costs for hyperbaric oxygen therapy except for anaerobic life-threatening infections;

3.28 all costs for erythropoetin unless accepted, by the disease or hospital benefit management programme where applicable;

3.29 all costs in respect of injuries sustained while voluntarily participating in a riot, civil commotion, war, invasion, act of foreign enemy, hostilities whether war is declared or not, and civil war; except for PMB's;

3.30 all costs for medical treatment as a result of exposure to nuclear or radio-active material or waste, except for prescribed minimum benefits as per regulation 8 of the Act;

3.31 all costs for autopsies;

3.32 all costs for medicines not approved by the Medicine Control Council;

3.33 all costs for contact lenses under the Essential Option only;

3.34 all costs in respect of orthognathic surgery;

3.35 all costs related to elective hip and knee replacements under the Essential option only.

* This healthcare service or product will be re-imbursed as long as you use a healthcare provider who is appropriately registered with the Board of Healthcare Funder's (BHF) and provided that this healthcare service or product has a valid tariff code or nappi code, ICD10 code and price.

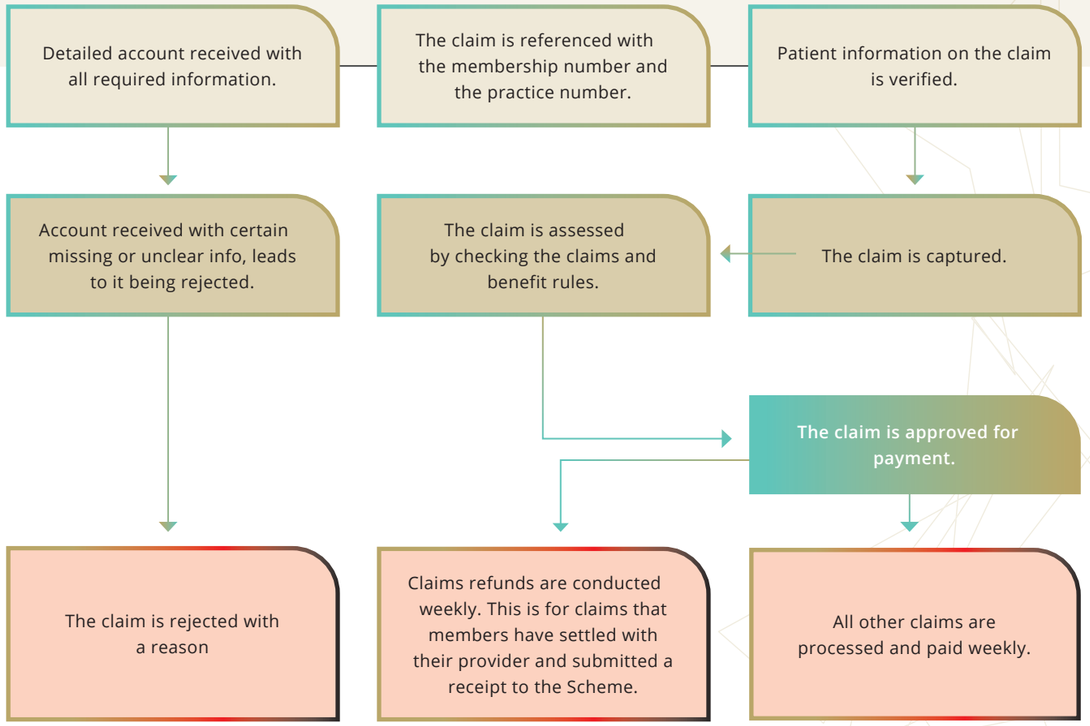
We will pay for this healthcare service from the Medical Savings Account (MSA) up to 100% of the Scheme Tariff.

ADMIN HOW-TO'S

Remember:
If you're injured in an accident, call the Customer Care Centre on 0860 002 133 to find out the procedure and paperwork to be completed to submit a third-party claim.

CLAIMS SUBMISSION

Life's uncertain enough without medical schemes being complicated too, so we've unpacked our 'claims chain' to give you insight into the admin of our Scheme.



APPLICABLE TO BOTH REJECTED AND APPROVED CLAIMS

If you have a valid email address, your assessed claims will be sent to you twice a month in your claims notification. If you do not have an email address, your claims statement will be posted to you.

Q&A: CLAIMS

WHO IS RESPONSIBLE FOR SUBMITTING MY CLAIMS?

Many service providers will submit accounts for you. But whether they do or not, you're ultimately responsible for submitting your accounts. Check your claims statements thoroughly and often, so that you're always on top of things.

WHAT INFORMATION SHOULD APPEAR ON MY CLAIM TO ENSURE PAYMENT?

The following information should appear on your claim:

- Your name and initials
- The patient's name, as shown on the membership card
- Your membership number
- The treatment date
- The amount charged
- The tariff code/s (where applicable)
- The ICD-10 code/s.

Members on the Essential Option who see a Specialist must also ensure that the referring GP's name is reflected.

HOW CAN I SUBMIT MY CLAIM?

If you're submitting the claim; email, post or deliver a clear and easily readable copy to the Scheme as soon as possible. Send a detailed invoice – please don't send statements.

If you've already paid the claim, attach your receipt and mark the account "PAID". Most important is your claims statement which you'll receive when the Scheme processes a claim for you during that month. Like a bank statement, this shows payments made to you or for you (with explanations of the various pay codes, so you understand why something may not have been covered).

You can submit your claims through the following methods:

Email: claims@sabmas.co.za

Post: PO Box 10436, Johannesburg, 2000

Important!

You have four months from the date of your treatment during which to submit your account.

WHEN AND HOW MUCH CAN I EXPECT TO BE PAID?

The Scheme has two statement runs per month for both members and suppliers. However, claims will be paid weekly.

- Accounts charged equal to our tariff will be paid directly and in full, once benefit rules have been applied, to the supplier.
- Accounts charged above our tariff will be paid directly to the provider at the Scheme Rate. The member will be liable to cover the difference between the Scheme Rate and the amount charged by the provider, in line with the Scheme Rules per Benefit Option.
- Accounts with a receipt to prove your payment will be refunded to you.
- Any co-payments owed by you to the Scheme will either be deducted from available savings (Comprehensive Option) or deducted from your salary or alternatively, deducted by debit order, if you are a self-paying member (Comprehensive and Essential Options).
- However, if you are due for a refund, any co-payments that are due by you in the same payment run will be offset against the refund*.

* Refunds are paid into your bank account because it is safest that way, so always let the Scheme know of changes to your banking details.

WHAT CAN I DO TO AVOID PAYMENTS OUT OF POCKET?

If you're submitting the claim; email, post or deliver a clear and easily readable copy to the Scheme as soon as possible. check which of your benefits are limited and whether you have available limits read your statements to understand the reasons why claims have not paid and contact your health professional if necessary to amend the account read your brochure to understand when you may need to pre-authosrise your procedure minimise shortfalls on your claims by visiting your nominated GP on Essential Option and use the Find a Healthcare Provider tool on www.sabmas.co.za to find a health professional we have an agreement with.

HOW DO I TRACK CLAIMS ONLINE?

If you have Internet access, **www.sabmas.co.za** will show your updated claim, benefit details and information. This data is password protected for your security, so you'll need to register, confirm your password and then log in.

Follow these easy steps to register on the website:

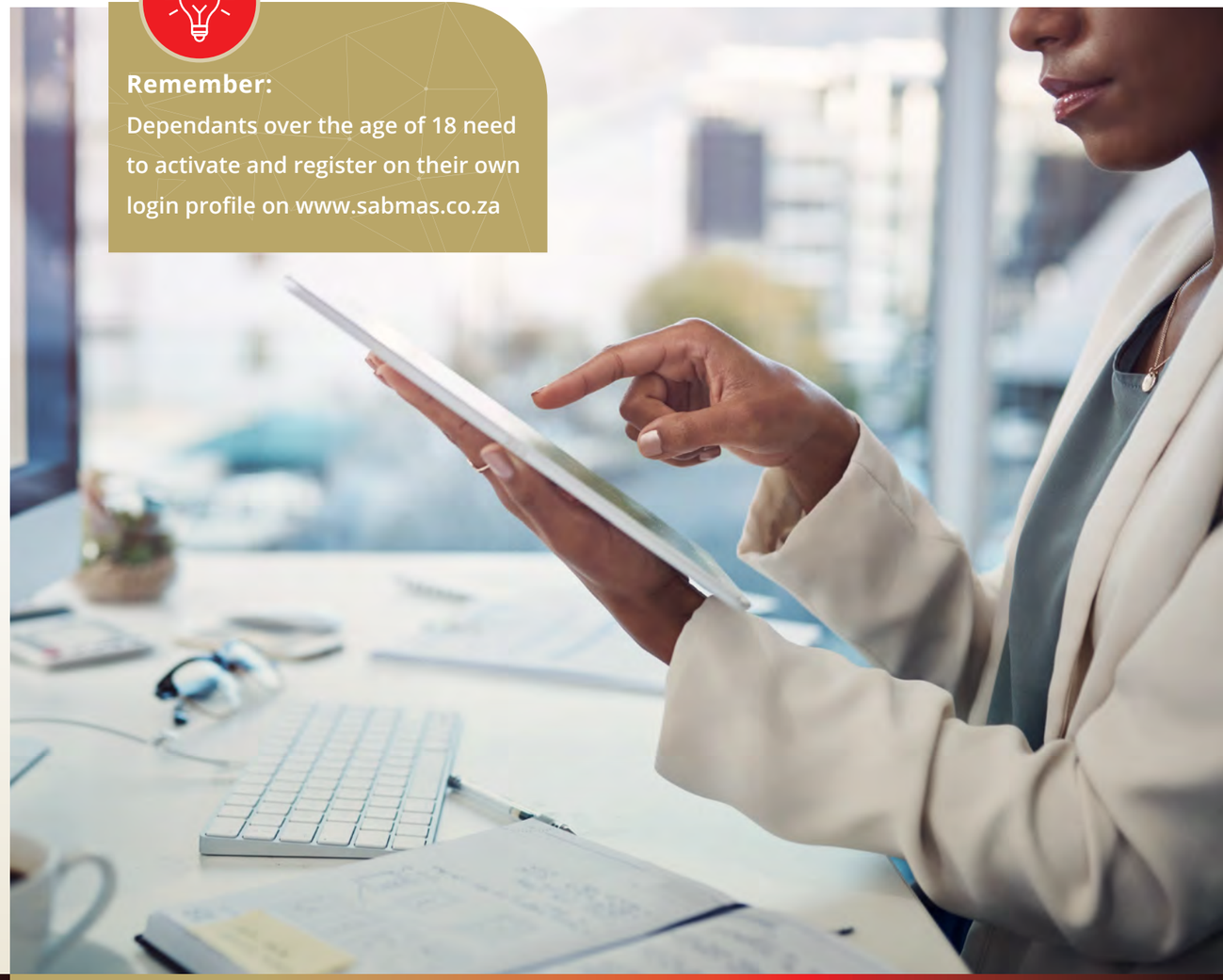
1. Go to www.sabmas.co.za.
2. Click on the Register button on the top right hand side of the screen.
3. Select your identification type from the dropdown menu. You can choose either ID or passport number. We use this information to confirm that you are allowed to register.
4. Choose if you would like to receive your One Time Password (OTP) by SMS or email.
5. Once you have received and entered your OTP, click Continue.
6. Select a username – the username you choose is permanent and cannot be changed.
7. Create a password.

Once you are logged in you can:

- View your membership details
- View and edit your contact details
- Find your claims and monitor their status
- View claims statements
- Locate a Network Provider
- View authorisations for chronic conditions along with baskets of care.

Remember:

Dependants over the age of 18 need to activate and register on their own login profile on www.sabmas.co.za



ADMIN INFORMATION

IMPORTANT THINGS TO REMEMBER

- Comprehensive Option members should check your Medical Savings Account often so that you're prepared for any co-payments you may need to make.
- Save money by using the Healthcare Providers in our GP, Optometry, Specialist Networks and Pharmacy Networks.
- Feel free to negotiate with specialists who don't charge Scheme Rates.
- Check with your pharmacist for alternatives if you have co-payments.

MEMBERSHIP

Only full-time permanent employees of South African Breweries and participating employers can join SAB Medical Aid. This is a condition of employment when you join.

PLEASE NOTE: If you're registered as a dependant on your partner's medical scheme, you cannot join SAB Medical Aid, because the Medical Schemes Act does not allow individuals to be members of more than one medical scheme at a time.

WHO QUALIFIES AS A DEPENDANT?

The following individuals qualify as dependants:

- Your spouse or partner.
- Your children, stepchildren or adopted children, or any children in your custody.
- A registered student at university or recognised institution of higher learning.
- A dependant not permanently employed.
- A child of 21 years or older who is mentally or physically disabled and does not work.
- Your grandchild may qualify as a dependant if you are their legal guardian or if their parent is a dependant on your medical scheme.
- Your financially dependent parent or parent-in-law may qualify as a dependant, subject to certain criteria being met (additional information and documentation needed to determine eligibility for dependent membership of a parent/parent-in-law will be requested on the application form).
- We may ask you for evidence of the status of your dependant.

WHAT ABOUT PENSIONERS, SURVIVING SPOUSES AND DISABILITY CLAIMANTS?

These individuals may remain on the Scheme and receive the same benefits as other members, but only if:

Pensioner members:

- Have retired from their employers; or
- Are members of the Scheme before retiring.

A surviving spouse and child members:

- Are registered as dependants at the time of the member's death, including a posthumous child (a child conceived before the time of the principal member's death).

Disability claimants:

- Are members of the Scheme before they become disabled; and
- Are placed on disability by their employer's disability insurers.

WAITING PERIODS

The Scheme does not impose waiting periods or any other penalties on new employees joining the Scheme within 90 days of employment, or on regular dependants (e.g. spouse or child) joining within 90 days of becoming eligible to join e.g. through marriage or birth. But please be aware that a three-month general waiting period and/or a 12 month condition-specific waiting period and/or a late joiner penalty may be applied if you/they join the Scheme at any other time. You are also allowed to add your financially dependent parents/parents-in-law as your dependants. However, if they were not your dependants on your previous medical scheme, i.e. if they are transferring to SAB Medical Aid on a voluntary basis, waiting periods and/or late joiner penalties may be imposed, even if they join within 90 days of you becoming a member.

LATE JOINER PENALTIES

If you're a 'late joiner', i.e. any beneficiary over the age of 35 years who has not had medical scheme cover for a number of years, you may be subject to certain penalties as stipulated in the Medical Schemes Act. These depend on how long you had no cover. Late joiner penalties are applied as follows:

NUMBER OF YEARS NOT ON A MEDICAL SCHEME	MAXIMUM PENALTY
1 – 4 years	5% increase in contribution
5 – 14 years	25% increase in contribution
15 – 24 years	50% increase in contribution
25+ years	75% increase in contribution

CONSENT AND CONFIDENTIALITY

We are committed to safeguarding and protecting your personal information. As part of this commitment, we need written consent from the principal member or dependant for us to disclose any personal, medical or claims information to a third party such as your doctor, specialist or employer.

Any dependant on your policy older than 18 years also needs to give consent for you to access their information. You will need to complete a document highlighting what information each beneficiary will have access to.

This *Third-party consent* form is available on the website at **www.sabmas.co.za** or you can contact the Customer Care Centre on **0860 002 133** and they will send you one.

IMPORTANT!

Please notify the Scheme of any changes to your postal and residential address, email address, contact numbers and marital status.
Divorced spouses no longer qualify for membership from the first of the month following the effective date of the divorce. The principal member is responsible for advising the Scheme
Common law spouses cannot remain members of the Scheme once the relationship has ended.
If you resign from a participating employer, your membership will be terminated as you are no longer eligible to be a member of the Scheme.
Non-payment of contributions and co-payments will result in suspension of your membership after 30 days and can result in termination.

Q&A PROVIDER NETWORKS

Medical schemes are required by law to pay Prescribed Minimum Benefit (PMB) claims at cost. This has significantly increased the financial burden on all medical schemes. In the long term, this may impact members by way of excessive contribution increases.

WHAT HAS SAB MEDICAL AID DONE TO PROTECT ITS MEMBERS FROM RISING COSTS?

In an attempt to control the risk of escalating costs to our members and the Scheme, the Board of Trustees has introduced a GP, Optometry and Specialist Network.

WHAT IS THE BENEFIT OF HAVING THESE NETWORKS?

The Scheme has contracted with a group of providers to deliver quality healthcare services to you at a pre-negotiated rate.
In order to avoid co-payments, you are encouraged to use these Networks for treatment both in-and out-of-hospital. In partnering with these providers, the Scheme can manage claims costs, which helps us to keep contribution increases as low as possible while still offering you great benefits.

For your convenience, the Scheme will pay the Network Providers directly and in full, sparing you any up-front payments.

ARE MEMBERS ALLOWED TO USE A PROVIDER OUTSIDE OF THE NETWORK?

Members on the Comprehensive Option are entitled to use a provider of your choice; however, if they charge above the Scheme Rate, you will have to pay the difference from your own pocket. If a non-network provider charges more than the Scheme Rate, we will pay the claim.

All members on the Essential Option will be required to choose a GP but will be allowed 3 consultations per year with a different GP.

CAN I SEE A SPECIALIST WITHOUT VISITING A GP FIRST?

Members on both options need to see a GP first. If you don't we will only pay 60% of the Scheme Rate.

WHAT HAPPENS IN AN EMERGENCY?

We know that your family's health is the most important thing to you, so we do not expect you to shop around for a provider on the Network in the event of an emergency. PMB claims, such as claims arising from a stroke or heart attack, will be covered in full, whilst non-PMB claims will be covered at the Scheme Rate if a non-network provider is used.

WHAT ROLE CAN YOU PLAY?

As a member of the Scheme you are encouraged to play a part in protecting your Scheme against rising healthcare costs.
Please contact the Customer Care Centre on 0860 002 133 or visit **www.sabmas.co.za** (click on DOCTOR and then *Find a Healthcare Provider*), to determine whether your provider is on a network.

WHAT ABOUT OTHER PROVIDERS ASSISTING IN THE PROCEDURE?

Do not assume that if the attending provider is in the Network, the other providers are also in the Network.

Check if they are part of the Network and discuss their rates beforehand. Visit **www.sabmas.co.za** (click on DOCTOR and then *Find a Healthcare Provider*) or contact the Customer Care Centre who can assist you with recommendations of Network Providers.

WHAT MORE CAN YOU EXPECT?

There is a sustained effort to ensure the Network continues to grow, to make it easy and convenient for each member to access quality healthcare at a contained cost.

CONTACT US

	TELEPHONE AND FAX	EMAIL	POSTAL ADDRESS AND PHYSICAL ADDRESS
CUSTOMER CARE CENTRE	Tel: 0860 002 133	Queries: info@sabmas.co.za Claims: claims@sabmas.co.za Membership changes: membership@sabmas.co.za	Po Box 10436, Johannesburg, 2000 7 West Street, Houghton Johannesburg
AID FOR AIDS	Tel: 0860 100 646 Fax: 0800 600 773 Confidential SMS line: 083 410 9078	afa@afadm.co.za	
AUTHORISATIONS	Tel: 0860 002 133	authorisations@sabmas.co.za	
CHRONIC	Tel: 0860 002 133	chronic@sabmas.co.za	
ONCOLOGY	Tel: 0860 002 133	oncology@sabmas.co.za	
NETCARE 911 (EMERGENCIES)	Tel: 082 911		
SCHEME WEBSITE	www.sabmas.co.za		

FORENSICS

If you even slightly suspect someone of committing fraud, report all information directly to the fraud department:

Toll-free phone: 0800 204 702
Toll-free fax: 0800 00 77 88
Email: sabmas@tip-offs.com

COMPLAINTS AND APPEALS

The Scheme Rules allow you to lodge a complaint or appeal. Your first step would be to lodge your complaint with the administrator, by calling us on **0860 002 133**, sending an email to **info@sabmas.co.za** or by post to PO Box 10436, Johannesburg, 2000. If you are not satisfied with the response, you may forward your complaint to the Principal Officer (PO Box 10436, Johannesburg, 2000), who may refer it to the Board of Trustees or an Independent Disputes Committee, if necessary. If you are still not happy with the outcome, you can lodge your complaint with the Council for Medical Schemes (CMS), which oversees all medical schemes and will treat each individual case on its merit.

Complaints can be submitted to CMS, by any reasonable means such as a letter, fax, email or in person:

Fax: 086 673 2466

Email: complaints@medicalschemes.com

Postal address:
Private Bag X34, Hatfield 0028

Physical address:
Block A, Eco Glades 2 Office Park,
420 Witch-Hazel Avenue, Eco Park,
Centurion 0157

Website: www.medicalschemes.co.za

SAB Medical Aid, registration number 1209, is regulated by the Council of Medical Schemes and administered by 3Sixty Health (Pty) Ltd, registration number 1978/001109/07, an accredited administration and managed care provider.

V.14 - 29/10/2024