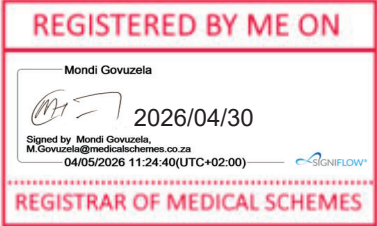


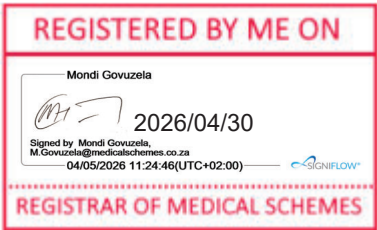
ANNEXURE C 2026

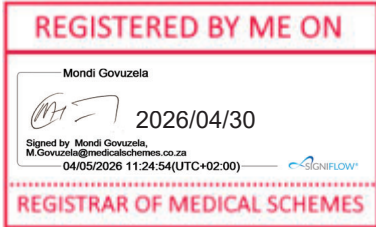
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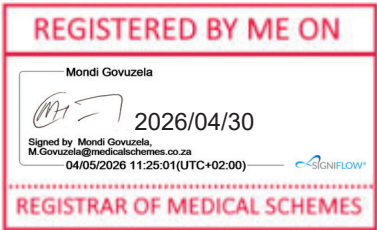
SUBJECT TO THE PROVISIONS OF THE SCHEME RULES, MEMBERS AND THEIR REGISTERED DEPENDANTS ARE ENTITLED TO THE FOLLOWING BENEFITS:

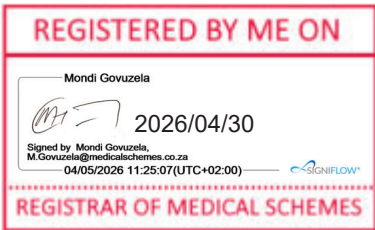
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
A	STATUTORY PRESCRIBED MINIMUM BENEFITS (PMBs)	100% of cost, but subject to PMB legislation.	Unlimited, but subject to PMB legislation.	- As provided for in Annexure G of the GEMS Rules. - Prescribed Minimum Benefits (“PMBs”) are not subject to the monetary benefit limits stated in this Annexure and shall be paid in full, where the diagnosis, treatment and care of a Prescribed Minimum

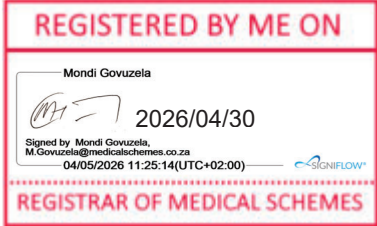
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				Benefit Condition were obtained from: ▪ a Designated Service Provider (“DSP”) for that condition; ▪ a non-DSP, if no DSP for that condition exists; or ▪ a non-DSP involuntarily, as described in Regulation 8 (3) of the General Regulations promulgated under the Medical Schemes Act 131 of 1998 (as amended),

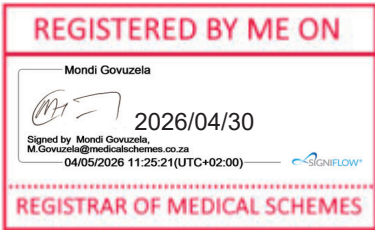
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				subject to: ▪ Authorisation, managed care protocols, formulary and processes, as specified under B: In-Hospital Benefits and C: Out-of-Hospital Benefits; and ▪ The Act. • This Rule supersedes all other benefit provisions in this Annexure.
B	IN-HOSPITAL BENEFITS		No overall limit.	
B1	Public Hospitals, Private Hospitals, Registered Unattached Theatres, Day	100% of Scheme Rate, subject to PMBs.	Unlimited, but subject to PMB legislation.	• All limits are subject to A: Statutory Prescribed

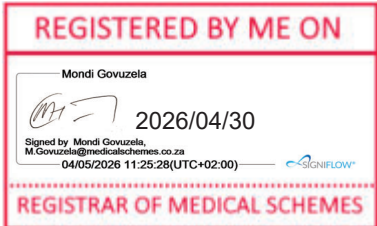
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	Clinics and Psychiatric Facilities 1. Accommodation in a general ward, high care ward and intensive care unit; 2. Theatre fees; 3. Medicines, materials and hospital equipment (includes bone cement for prostheses (B14)); and 4. Neonatal care. 			Minimum Benefits (“PMBs”). • Hospital authorisation for admission to a Private facility must be obtained from the Scheme’s managed care provider at least 48 hours before a Beneficiary is admitted to a Private facility (except in the event of an Emergency Medical Condition), failing which, a co-payment of R1 000 per admission shall apply. • In the event of an admission to a Private

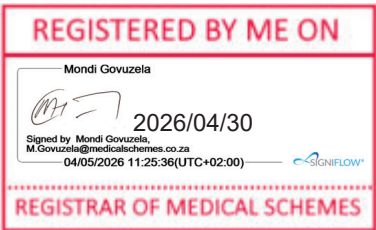
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				facility for an Emergency Medical Condition, the Scheme must be notified of such admission within one (1) working day after the admission, failing which, a co-payment of R1 000 per admission shall apply. • Accommodation in a private ward is subject to motivation by attending practitioner and Scheme's managed care protocols and processes. • All In-Hospital treatment and services are subject to hospital authorisation

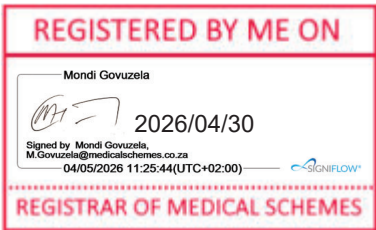
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				(for Private facilities only, and inclusive of non-PMB one-day admissions), managed care protocols and processes. A co-payment of R1000 per scope shall apply in respect of elective colonoscopies and gastroscopies performed in acute hospitals.
B2	Maternity Hospital, home birth or registered birthing unit.	100% of cost, but subject to PMB legislation.	Unlimited, but subject to PMB legislation.	All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs").

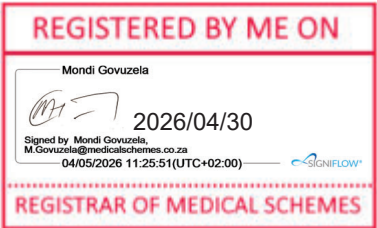
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				• Subject to managed care protocols and processes. • Hospital authorisation for admission to a Private facility must be obtained from the Scheme's managed care service provider at least 48 hours before a Beneficiary is admitted to a Private facility (except in the event of an Emergency Medical Condition), failing which, a co-payment of R1 000 per admission shall apply.

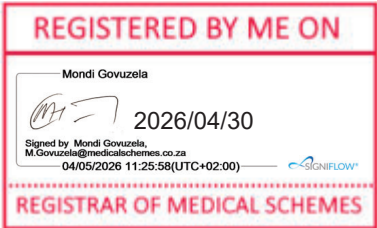
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				- In the event of an admission to a Private facility for an Emergency Medical Condition, the Scheme must be notified of such admission within one (1) working day after the admission, failing which, the co-payment of R1 000 per admission shall apply. - Elective Caesarean Sections may be subjected to second opinion, managed care protocols and processes.

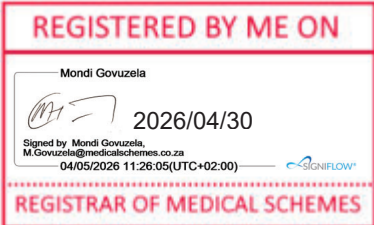
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				- Benefit includes midwife services. - Includes non-invasive prenatal testing for high-risk pregnancies, subject to pre-authorisation.
B3	Family Practitioner Services Consultations and visits.	100% of Scheme Rate for non-Network Family Practitioners. 130% of Scheme Rate for Network Family Practitioners.	Unlimited. Reimbursement according to the Scheme-approved tariff file.	All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs").
B4	Specialist Services Consultations and visits.	100% of Scheme Rate for non-Network Specialists.	Unlimited. Reimbursement according to the Scheme-approved tariff file.	All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs").

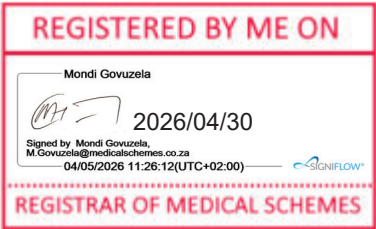
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
		130% of Scheme Rate for Network Specialists.		
B5	Surgical Procedures 	100% of Scheme Rate. 200% of Scheme Rate for procedures specified by managed care, performed in practitioners' rooms instead of in hospital.	Unlimited. Refer to Annexure E (Exclusions and Limitations) of GEMS Rules.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to Private hospital pre-authorisation, managed care protocols and processes. • Includes: ○ Hospital procedures performed in practitioner's rooms, as approved by the Scheme;

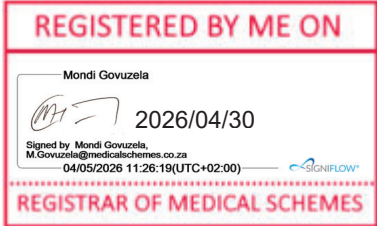
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				○ Maxillofacial Surgery; and ○ Surgical removal of impacted teeth (In-Hospital and Out-of-Hospital).
B6	Dentistry Conservative, Restorative and Specialised Dentistry. Surgical Procedures.	100% of Scheme Rate.	Professional fees, subject to shared limits with C2: Dental Services. Hospital cost included in hospital benefit (B1). Dental Sealants: Excluded under B6: Dentistry and C2: Dental Services, but included under C14: Preventative Care Services for	● All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). ● Subject to Private hospital pre-authorisation, managed care protocols and processes, list of approved services, and use of Day Theatres.

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			Beneficiaries under 18 years of age. Refer to Annexure E (Exclusions and Limitations) of GEMS Rules.	- General Anaesthesia and Conscious Sedation: Only applicable to Beneficiaries:- - up to and including the age of six (6) years; or - with severe trauma, subject to pre-authorisation and managed care protocols and processes. - Implant crowns, bridges, and dentures, subject to pre-authorisation. - Services classified as conservative, restorative

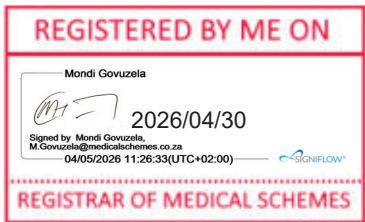
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				and specialised per tariff code.
B7	Basic Radiology X-rays and soft tissue ultrasound scans.	100% of Scheme Rate.	Unlimited.	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Subject to managed care protocols and processes.
B8	Advanced Radiology 	100% of Scheme Rate, subject to PMBs.	Shared limit with C9: Advanced Radiology of R29 694 per family per annum.	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Subject to Advanced Radiology authorisation (in addition to Private hospital pre-authorisation) for Angiography, CT scans,

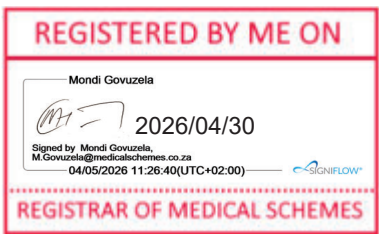
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				MDCT, Coronary Angiography, MUGA scans, PET scans, MRI scans and Radio-isotope studies. • Subject to managed care protocols and processes.
B9	Pathology	100% of Scheme Rate.	Unlimited.	• All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). • Subject to managed care protocols and processes, and pathology tests being related to admission diagnosis.

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
B10	Blood Services 	100% of Scheme Rate, subject to PMBs.	Unlimited, but subject to PMB legislation.	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Subject to managed care protocols and processes. - Includes cost of blood, blood equivalents, blood products and the transport thereof. - Includes Erythropoietin.
B11	Physiotherapy	100% of Scheme Rate, subject to PMBs.	Limited to R6 673 per Beneficiary per annum.	All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs").

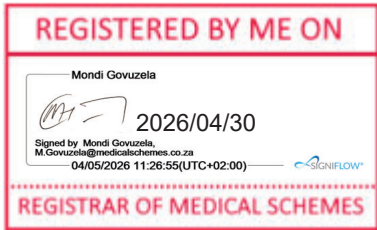
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				• Subject to Private hospital pre-authorisation, managed care protocols and processes, and services being related to admission diagnosis.
B12	Post Hip, Knee and Shoulder Replacement or Revision Surgery Physiotherapy	100% of Scheme Rate.	Limited to 10 post-surgery physiotherapy visits (shared with C1.6: Post Hip, Knee and Shoulder Replacement or Revision Surgery Physiotherapy) up to a limit of R7 044 per Beneficiary per event, utilised within sixty (60) days of surgery.	• All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). • Subject to Private hospital pre-authorisation, managed care protocols and processes.

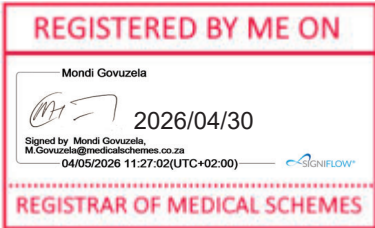
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B13	Organ and Tissue Transplants 	100% of Scheme Rate, subject to PMBs.	Limit of R824 901 per Beneficiary per annum. Sub-limit of R28 001 per Beneficiary per annum for corneal grafts (imported corneal grafts, subject to managed care protocols and processes.).	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Subject to Private hospital pre-authorisation, managed care protocols and processes, and use of facility as per B1. - Limit includes all costs associated with the transplant, including materials and immunosuppressants. - Erythropoietin included in B10: Blood Services.

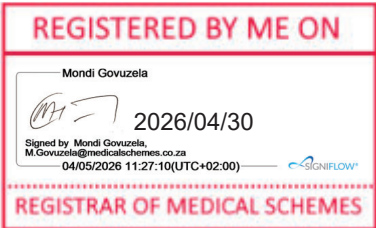
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				Organ harvesting is limited to the Republic of South Africa, except for cornea tissue.
B14	Prostheses This benefit covers temporary and permanent prostheses and internal devices (surgically implanted), and accompanying temporary or permanent devices used to assist with the guidance, alignment or delivery of these prostheses and internal devices.	100% of Scheme Rate, subject to PMBs.	Subject to: Shared limit with C11: Medical and Surgical Appliances and Prostheses of R56 131 per family per annum for Medical and Surgical Appliances and Prostheses generally, plus R56 131 per family per annum for Joint Revisions only; and	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Subject to managed care protocols and processes. - Scheme may obtain competitive quotes, or arrange supply of prosthesis. - Bone cement paid from B1, subject to Private

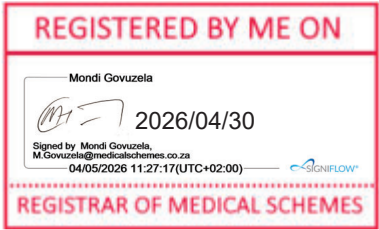
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			- Shared sub-limits with C11: Medical and Surgical Appliances and Prostheses of: - R6 164 per Beneficiary per annum for foot orthotics and prosthetics, with a sub-limit of R1 761 per Beneficiary per annum for orthotic shoes, foot/shoe/ankle inserts and levelers;	hospital pre-authorisation. - Foot orthotics and prosthetics, subject to formulary and managed care protocols and processes. - Subject to the prostheses and/or device(s) being related to the admission diagnosis and procedure. - Once the limit is depleted, the benefit is unlimited for PMBs.

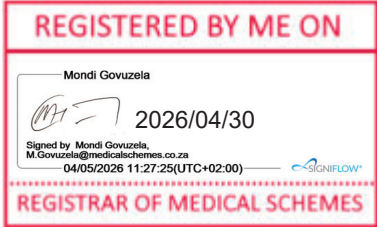
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			- o R701 for crutches per Beneficiary per annum; - o One (1) wheelchair of up to R7 716 per Beneficiary every thirty-six (36) months of month of receipt of wheelchair; - o One (1) unilateral hearing aid, or one (1) pair of bilateral hearing aids, of up to R11 223 per hearing aid per Beneficiary every thirty-six (36) months of month of	

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			receipt of hearing aid(s); One (1) CPAP device (including accessories) of up to R13 328 per Beneficiary every thirty-six (36) months of month of receipt of device; or one (1) APAP, BIPAP or VPAP device (including accessories) of up to R19 623 per Beneficiary every thirty-six (36) months of month of receipt of device;	

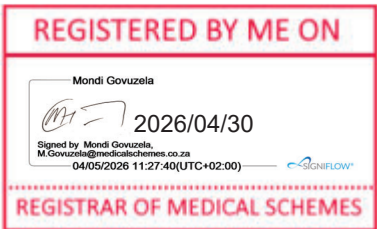
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			however, if a device is clinically indicated, but not prescribed by the Scheme's managed care protocols and processes, the device shall be funded in accordance with the limits applicable to CPAP devices; Three (3) pairs of compression stockings of up to R584 per pair per Beneficiary per annum;	

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			- One (1) Pulse Oximeter of up to R467 per Family per annum; and - One (1) knee and one (1) back brace of up to R3 499 per brace per Beneficiary per annum.	
B15	Emergency Services (Casualty Department)	100% of cost, but subject to PMB legislation.	Limited to PMBs (Emergency Medical Condition, as defined in Section 4 of the main body and Annexure G of the GEMS Rules).	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Subject to use of facility as per B1, or other registered emergency facility.

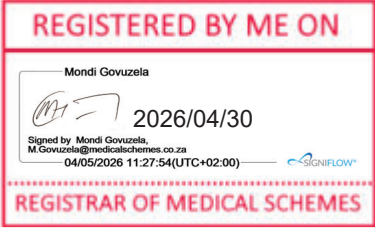
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				• Subject to Private hospital authorisation, managed care protocols and processes. • Cost to be defrayed from C1.1: Family Practitioner (FP) Services, for non-PMB and unauthorised events.
B16	Renal Dialysis In-Hospital	100% of Scheme Rate, subject to PMBs.	Limit of R353 521 per Beneficiary per annum for chronic dialysis. Acute dialysis included in B1.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to Private hospital pre-authorisation, managed care protocols and

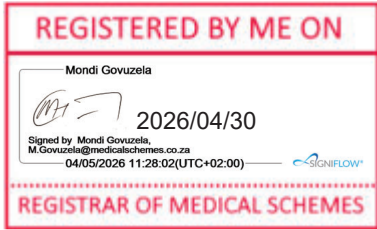
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				processes, and use of facility as per B1. - Includes related materials, and related pathology and radiology tests, but subject to managed care protocols and processes. - Erythropoietin included in B10: Blood Services. - Once the limit is depleted, the benefit is unlimited for PMBs.
B17	Oncology (Chemo and Radiotherapy) In- and Out-of-Hospital	100% of Scheme Rate, subject to PMBs.	Limit of R494 945 per family per annum. Sub-limit of R336 702 per family for biological	All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs").

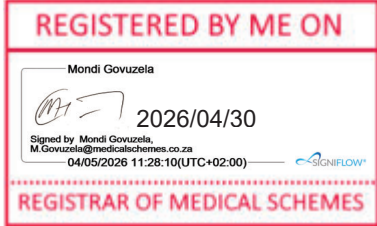
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			and similar specialised medicine.	• Subject to Oncology pre-authorisation and managed care protocols and processes. • Subject to Drug Reference Price (DRP). • Subject to use of facility as per B1, or a registered alternative. • Includes cost of pathology, related basic/advanced radiology, medical technologists, oncology medicines and materials. • Erythropoietin included in B10: Blood Services.

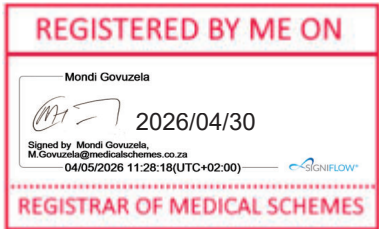
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				- Once the limit is depleted, the benefit is unlimited for PMBs. - Excludes new chemotherapeutic medicines that have not convincingly demonstrated a survival advantage of more than three (3) months in advanced or metastatic solid organ malignant tumours, unless pre-authorized in accordance with paragraph 9.1.13.6 of Annexure E (Exclusions and Limitations) of GEMS Rules.

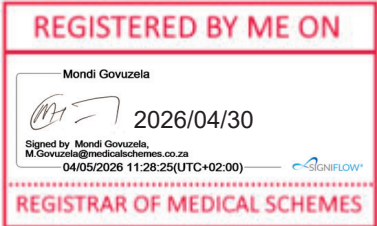
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B18	Mental Health: Accommodation, theatre fees, medicine, hospital equipment and professional fees of Family Practitioners, Psychiatrists and Psychologists.	100% of Scheme Rate, subject to PMBs.	Subject to: - Limit of R24 746 per family per annum, shared between B18: Mental Health and C10: Mental Health; - Shared sub-limit with C10: Mental Health of R2 879 per family per annum for services by Educational and Industrial Psychologists; and - Limit of one (1) individual Psychologist	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Subject to Private hospital pre-authorisation and managed care protocols and processes. - Subject to use of facility as per B1, or a registered alternative. - Maximum of three (3) days hospitalisation by a Family Practitioner.

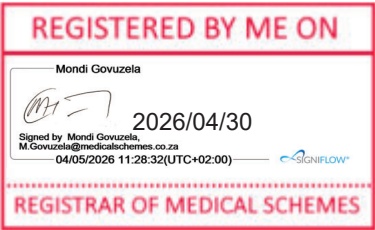
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			consultation and one (1) group Psychologist consultation per day.	
B19	Alternatives to Hospitalisation 1. Sub-acute Hospitals, Physical Rehabilitation, Private Nursing and Intravenous (IV) Therapy. 2. Hospice	1. 100% of Scheme Rate, subject to PMBs. 2. 100% of cost, but subject to PMB legislation.	1. Unlimited, subject to PMB legislation. 2. Unlimited, but subject to PMB legislation.	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Subject to pre-authorisation of alternative facility and services, and managed care protocols and processes. - Includes home nursing, but subject to managed

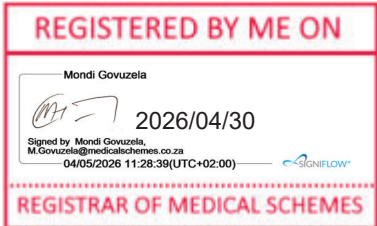
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				care protocols and processes. - Excludes Frail Care and recuperative holidays. - Refer to Annexure E (Exclusions and Limitations) of GEMS Rules.
B20	Medical Technologists	100% of Scheme Rate, subject to PMBs.	Unlimited, subject to PMB legislation.	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Subject to Private hospital pre-authorisation and case management. - Includes materials.

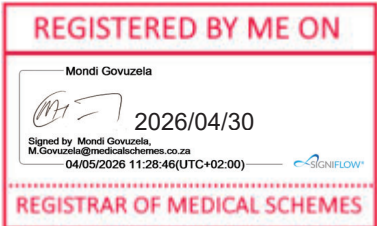
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B21	Breast Reductions 	100% of Scheme Rate, subject to PMBs.	Unlimited, subject to PMB legislation.	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Subject to pre-authorisation, managed care protocols and processes.
B22	Allied Health Services: Limited to Chiropractors, Homeopaths, Phytotherapists, Acupuncturists and Chinese Medicine Practitioners.	100% of Scheme Rate, subject to PMBs.	Limit of R2 128 per family per annum, shared between B22: Allied Health Services, B23: Other Professional Health Services, C5: Allied Health Services, and C6: Other Professional Health Services.	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Subject to managed care protocols and processes, and services being related to admission diagnosis.

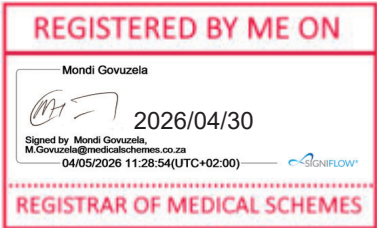
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
B23	Other Professional Health Services Including Dieticians, Podiatrists, Social Workers, Registered Counsellors and Orthoptists. 	100% of Scheme Rate, subject to PMBs.	Shared limit as per B22: Allied Health Services; and Sub-limit of R1 652 per family per annum for Social Workers and Registered Counsellors, shared between B23: Other Professional Health Services and C6: Other Professional Health Services.	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Subject to managed care protocols and processes, and services being related to admission diagnosis.
B24	Alcohol and Drug Dependencies	100% of cost, but subject to PMB legislation.	Limited to PMBs.	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Subject to pre-authorisation of DSP

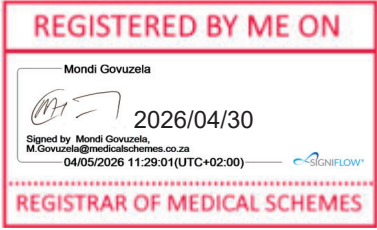
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				facility, managed care protocols and processes, and use of DSP facility as per Annexure G (Prescribed Minimum Benefits) of GEMS Rules.
C	OUT-OF-HOSPITAL BENEFITS			
C1	Day-to-Day Block Benefit - Out-of-Hospital Family Practitioner Services; - Out-of-Hospital Specialist Services; - Physiotherapy;	100% of Scheme Rate.	Shared limit between C1.1 and C1.4 – C1.9 of R12 351 per family, and R6 173 per Beneficiary, per annum.	- All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). - Benefit is pro-rated from date of admission of Beneficiary to end of financial year.

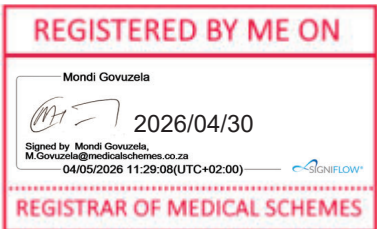
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	4. Maternity (where not covered under C7: Maternity Programme); 5. Audiology, Occupational Therapy and Speech Therapy; and 6. Pathology and Medical Technology.			
C1.1	Family Practitioner (FP) Services Consultations, visits and all other Family Practitioner services not specifically provided for otherwise in this Annexure.	100% of Scheme Rate for non-Network Family Practitioners. 130% of Scheme Rate for Network Family Practitioners. Reimbursement at 200% of Scheme Rate for procedures specified by managed	Shared limit as per C1: Day-to-Day Block Benefit.	- All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). - Benefit includes consultations, visits and approved minor procedures at Family Practitioners, subject to medical necessity and

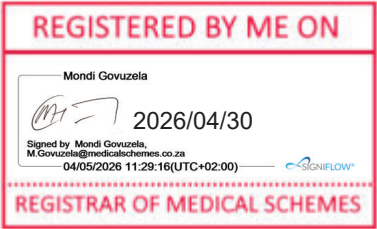
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		care, performed in practitioners' rooms instead of in hospital.		managed care protocols and processes. Limit is pro-rated from date of admission of Member to end of financial year.
C1.2	Primary Care Extender Benefit	100% of Scheme Rate, subject to PMBs.	Payable from Risk. Shared limit between: - C1.1: Family Practitioner (FP) Services; - C1.9: Pathology and Medical Technology; and - C8.1: Prescribed Medication and Injection Material,	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - The additional benefit of R2 063 per Beneficiary per annum is: - In the case of C1.1: Family Practitioner (FP) Services, subject to:

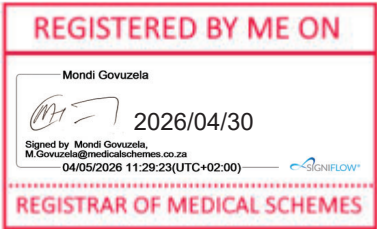
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			i.e. Acute Medical Conditions, of R2 063 per Beneficiary per annum, when any of aforementioned benefits are exhausted.	▪ Use of Network Family Practitioner; and ▪ Managed care protocols and processes. ○ In the case of C1.9: Pathology and Medical Technology, subject to: ▪ Managed care protocols and processes. ○ In the case of C8.1: Prescribed Medication and Injection Material, i.e. Acute Medical

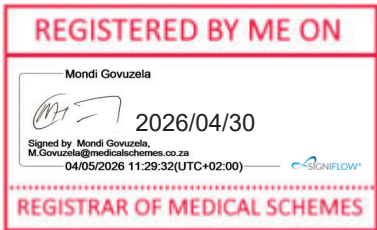
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				Conditions, subject to: ▪ The Conditions / Remarks provided for in C8: Prescribed Medication and Injection Material. • The additional benefit of R2 063 per Beneficiary per annum shall not be pro-rated, irrespective of the date of Beneficiary registration.
C1.3	Family Practitioner Network Extender Benefit for Beneficiaries with chronic conditions registered on	100% of Scheme Rate, subject to PMBs.	• Payable from Risk. • Two (2) additional Family Practitioner consultations at a	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs").

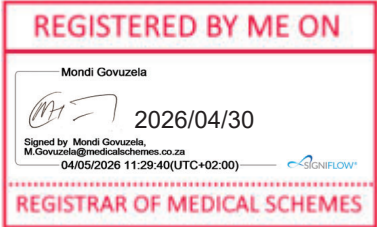
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	Disease Management Programme 		DSP/Network provider, once C1: Day-to-Day Block Benefit and C1.2: Primary Care Extender Benefit are exhausted.	The additional Family Practitioner consultations at a DSP/Network provider are subject to pre-authorisation, managed care protocols and processes.
C1.4	Specialist Services Consultations, visits and all other Specialist services not specifically provided for otherwise in this Annexure.	100% of Scheme Rate for non-Network Specialists. 130% of Scheme Rate for Network Specialists. 200% of Scheme Rate for procedures specified by managed care,	Shared limit as per C1: Day-to-Day Block Benefit.	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Limit is pro-rated from date of admission of Member to end of financial year.

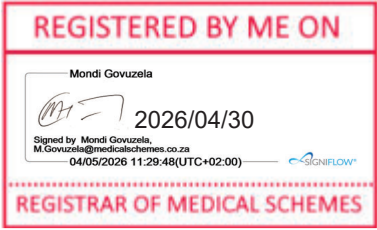
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		performed in practitioners' rooms instead of in-hospital. 200% of Scheme Rate for cataract procedures performed by Ophthalmologists in their rooms.		
C1.5	Physiotherapy	100% of Scheme Rate, subject to PMBs.	Shared limit as per C1: Day-to-Day Block Benefit. Sub-limit of R6 132 per family, and R3 066 per Beneficiary, per annum.	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Subject to managed care protocols and processes.

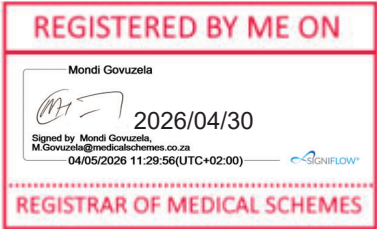
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C1.6	Post Hip, Knee and Shoulder Replacement or Revision Physiotherapy 	100% of Scheme Rate.	Shared limit as per C1: Day-to-Day Block Benefit. Limited to 10 post-surgery physiotherapy visits (shared with B12: Post Hip, Knee and Shoulder Replacement or Revision Surgery Physiotherapy) up to a limit of R7 044 per Beneficiary per event, utilised within sixty (60) days of surgery.	- All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). - Subject to Private hospital pre-authorisation, managed care protocols and processes.
C1.7	Maternity Ante- and post-natal care.	100% of Scheme Rate.	Shared limit as per C1: Day-to-Day Block Benefit, where not	All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”).

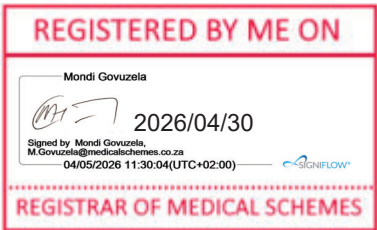
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			accessed under C7: Maternity Programme.	Includes non-invasive prenatal testing for high-risk pregnancies, subject to pre-authorisation.
C1.8	Audiology, Occupational Therapy and Speech Therapy 	100% of Scheme Rate.	Shared limit as per C1: Day-to-Day Block Benefit. Shared sub-limit with C1.9: Pathology and Medical Technology, of R6 034 per family, and R3 011 per Beneficiary, per annum. Further sub-limit of R4 840 per family, and R2 424 per Beneficiary, per annum.	- All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). - Subject to managed care protocols and processes. - Occupational or speech therapy performed In-Hospital shall be paid from B1.

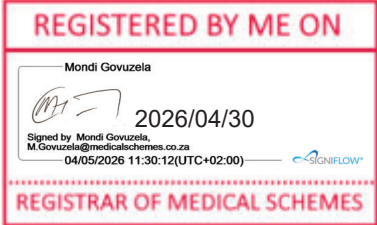
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C1.9	Pathology and Medical Technology 	100% of Scheme Rate.	Shared limit as per C1: Day-to-Day Block Benefit. Shared sub-limit with C1.8: Audiology, Occupational Therapy and Speech Therapy of R3 011 per Beneficiary and R6 034 per family per annum.	- All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). - Subject to managed care protocols and processes. - Includes liquid-based cytology and Hr-HPV DNA pap smears.
C2	Dental Services Conservative and Restorative Dentistry (include plastic dentures); Special Dentistry (includes metal-base dentures); and Surgical Procedures.	100% of Scheme Rate.	Shared limit with B6: Dentistry of R6 900 per Beneficiary per annum, provided that: Panoramic X-rays are limited to one (1) per Beneficiary	- All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). - Subject to managed care protocols and processes.

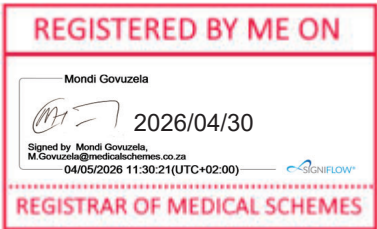
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			every three (3) years; ○ Bitewing X-rays are limited to six (6) per Beneficiary per annum; ○ Periapical X-rays are limited to ten (10) per Beneficiary per annum; and ○ Cone Beam Computed Tomography (CBCT) scans are limited to one (1) per Beneficiary per lifetime for surgical procedures.	• Conscious Sedation: Only applicable to Beneficiaries:- ○ up to and including the age of nine (9) years; or ○ with severe trauma, subject to pre-authorisation, managed care protocols and processes. • In respect of Conservative and Restorative Dentistry: ○ Panoramic, Bitewing and Periapical X-rays included. • In respect of Special Dentistry:

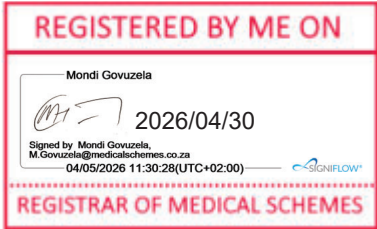
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			Dental Sealants: Excluded under B6: Dentistry and C2: Dental Services, but included under C14: Preventative Care Services for Beneficiaries under 18 years of age. Refer to Annexure E (Exclusions and Limitations) of the GEMS Rules.	○ No pre-authorisation required for metal base dentures. ● Implant crowns, bridges, and dentures, subject to pre-authorisation. ● Dental services classified as conservative, restorative and specialised per tariff code.
C3	Optical Services 1. Eye examinations; 2. Frames, lenses and contact lenses	100% of Scheme Rate.	Limited to R5 942 per family per financial year, starting on 01 January and ending on 31 December of the same	● All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs").

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
	(permanent and disposable); and 3. Refractive eye surgery. 		year ("Family Financial Cycle"). Further limited to R3 099 per Beneficiary for every two (2) financial years, calculated from 01 January of the year within which any Optical Service was first rendered to the affected Beneficiary following the end of such previous two (2) year period (if any) ended on 31 December ("Beneficiary Financial Cycle"), subject to frames not exceeding R1 636.	• All Optical services included in benefit. • Subject to Optical Managed Care protocols and processes. • Optical benefit is not pro-rated, irrespective of date of Beneficiary registration. • Includes tinted lenses, up to a tint of 35%, for albinism and proven photophobia, subject to pre-authorisation. • Excludes variable tint and photochromic lenses.

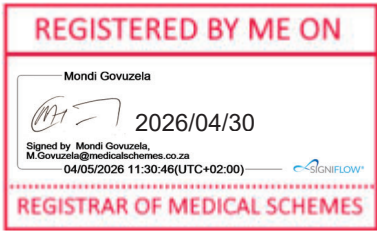
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			For Beneficiaries with Keratoconus, the family and Beneficiary limits specified hereinabove shall be subject to an additional optometry booster benefit of R2 751 per family per annum for scleral contact lenses. Limited to: One (1) eye examination per Beneficiary per twelve (12) month period, calculated from the month within which same was last rendered to	Refer to Annexure E (Exclusions and Limitations) of the GEMS Rules for Optometry Exclusions.

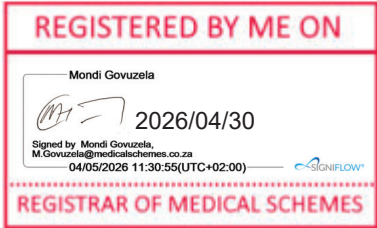
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			the affected Beneficiary ("Eye Examination Cycle"); and One (1) frame and one pair of lenses per Beneficiary per twenty-four (24) month period, calculated from the month within which same was last rendered to the affected Beneficiary ("Optical Appliance Cycle"). Save for the financial limits specified hereinabove, no limit	

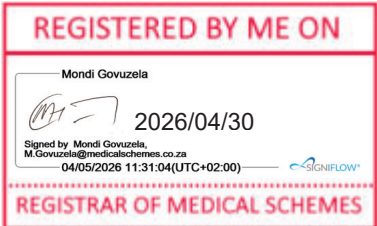
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			shall apply to the number of contact lenses that may be rendered to a Beneficiary. Either spectacles or contact lenses shall be funded in an Optical Appliance Cycle, not both. Post-cataract surgery, Optical PMB entitlement shall be limited to the cost of a bifocal lens, not exceeding R1 744 for both lens and frame, with a sublimit of R293 for the frame.	

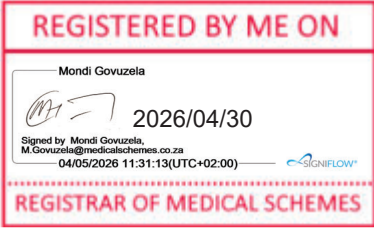
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C4	Basic Radiology X-rays and soft tissue ultrasound scans. 	100% of Scheme Rate.	Sub-limit of R4 930 per Beneficiary and R9 034 per family per annum.	- All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). - Subject to managed care protocols and processes. - Includes 2 x 2D ultrasound scans per pregnancy provided for under C7: Maternity Programme. Alternatively, should any such 2D scan be substituted with a 3D/4D scan, such 3D/4D scan shall be funded up to the cost of a 2D scan.

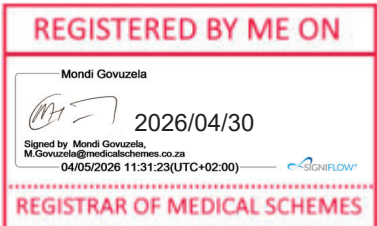
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C5	Allied Health Services: Limited to Chiropractors, Homeopaths, Phytotherapists, Acupuncturists and Chinese Medicine Practitioners.	100% of Scheme Rate, subject to PMBs.	Shared limit as per B22: Allied Health Services.	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Subject to managed care protocols and processes.
C6	Other Professional Health Services Limited to Dieticians, Podiatrists, Social Workers, Registered Counsellors and Orthoptists.	100% of Scheme Rate, subject to PMBs.	Shared limit and sub-limit as per B22: Allied Health Services and B23: Other Professional Health Services.	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Subject to managed care protocols and processes.
C7	Maternity Programme Ante- and post-natal care.	100% of Scheme Rate, subject to	Paid from Risk, but limited to Maternity Programme Benefits.	All limits are subject to A: Statutory Prescribed

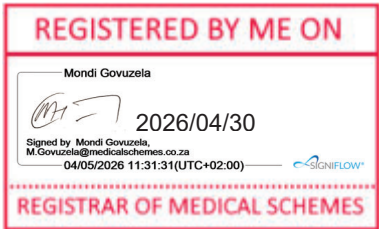
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		Maternity Programme Protocols.		Minimum Benefits (“PMBs”). • Subject to registration on Maternity Programme, and managed care protocols and processes. • If not registered on Maternity Programme, C1.7: Maternity shall apply. • Includes: ○ Benefits defined in managed care protocols. ○ 2 x 2D ultrasounds per pregnancy. Alternatively, should

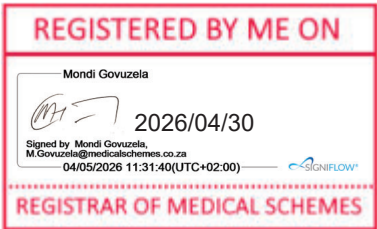
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				any such 2D scan be substituted with a 3D/4D scan, such 3D/4D scan shall be funded up to the cost of a 2D scan. Non-invasive prenatal testing for high-risk pregnancies, subject to pre-authorisation.
C8	Prescribed Medication and Injection Material			- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Prescribed, administered and dispensed by healthcare

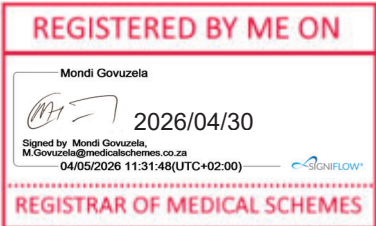
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	 1. Acute Medical Conditions.	1. 100% of Scheme Rate.	1. Limit of R14 847 per family, and R4 950 per Beneficiary, per annum, and sub-limit of R738 per family per annum for homeopathic medicine.	professionals, legally entitled to do so. • Subject to Drug Reference Price (DRP) and Medicine Exclusion List (MEL). • Subject to Annexure E (Exclusions and Limitations) of GEMS Rules. 1. Subject to the following: • Managed care protocols, formulary and processes. • Prescription by a healthcare professional, legally entitled to do so.

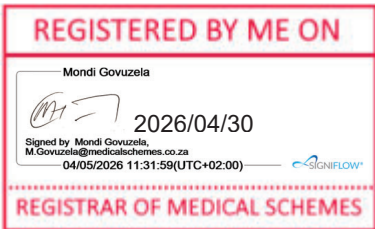
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	 2. Chronic Medical Conditions listed in PMB DTP, PMB CDL and Annexure D of the GEMS Rules.	2. 100% of Scheme Rate, subject to PMBs.	2. Unlimited for PMB chronic conditions listed in PMB DTP, PMB CDL and Annexure D of the GEMS Rules, but subject to PMB legislation and the following, which	- A 30% co-payment shall apply to voluntary use of Out-of-Formulary medicine, where Formulary exists. - Benefit includes prescribed maternity vitamin supplements. 2. Subject to the following: - Prior application and approval, Formulary, Drug Reference Price (DRP), managed care protocols and processes, and prescription by a healthcare professional legally entitled to do so.

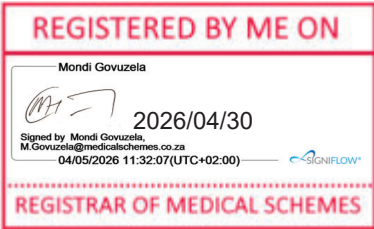
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			exceed PMB level of care: - Continuous Glucose Monitors (CGM) and Insulin Pumps: Subject to: - Limit of R28 324 per Beneficiary per annum for consumables (excluding devices, which are provided for under C11: Medical and Surgical Appliances and Prostheses); and - Limited to type one (1) diabetics aged	- Medicine for chronic conditions listed in PMB DTP, PMB CDL and Annexure D of the GEMS Rules, subject to use of Chronic Medicine Pharmacy DSP, as provided for in Annexure G (Prescribed Minimum Benefits) of the GEMS Rules. - A 30% co-payment shall apply for voluntary use of Out-of-Formulary medicine and voluntary use of a non-Chronic Medicine Pharmacy DSP.

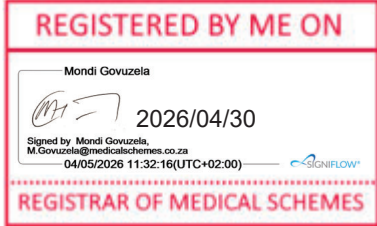
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			below nineteen (19) years. Limit of R29 897 per family, and R14 847 per Beneficiary, per annum for non-PMB chronic conditions listed in Annexure D of the GEMS Rules. No benefit for non-PMB chronic conditions not listed in Annexure D of the GEMS Rules.	Chronic Medical Conditions listed in PMB DTP, PMB CDL and Annexure D of the GEMS Rules, shall be paid from limit for non-PMB chronic conditions listed in Annexure D of the GEMS Rules; and once limit is exhausted, benefit shall be unlimited for PMBs, but subject to PMB legislation. However, consumables for Continuous Glucose Monitors (CGM) and Insulin Pumps for type one (1) diabetics aged below nineteen (19)

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				years shall not be paid from the aforementioned limit, but from the consumable limit for Continuous Glucose Monitors (CGM) and Insulin Pumps for type one (1) diabetics aged below nineteen (19) years only. Includes benefit for life-threatening allergies, payable from Risk, and subject to managed care protocols, formulary and processes.

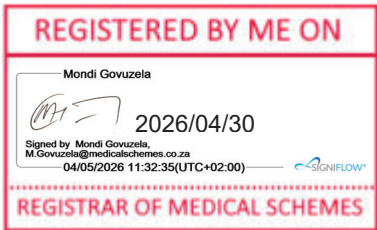
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	3. Self-Medication: Over-the-Counter (OTC) Medicine 	3. 100% of Scheme Rate.	3. Subject to acute medicine benefit limit (C8.1), event limit of R334 per Beneficiary, sub-limit of R1 247 per Beneficiary per annum, and a family annual limit of R1 994.	3. Subject to the following: - Managed care protocols, Formulary and processes. - Only SAHPRA-registered Schedule 0, 1, and 2 medicines payable from the OTC benefit.
	4. Prescribed medication from hospital stay (TTO).	4. 100% of Scheme Rate.	4. Included in acute medication benefit limit (C8.1). Payable from Risk, once acute medication benefit (C8.1) is exhausted.	4. Subject to the following: TTO limited to seven (7) days.

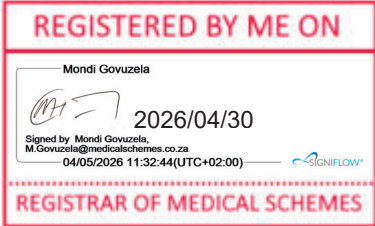
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	5. Female Contraceptives: Oral, insertables, injectables and dermal.	5. 100% of Scheme Rate.	5. Subject to acute medicine benefit limit (C8.1) and a sub- limit of R3 757 per Beneficiary per annum.	5. Subject to managed care protocols, Formulary and processes.
C9	Advanced Radiology 	100% of Scheme Rate, subject to PMBs.	Shared limit with B8: Advanced Radiology of R29 694 per family per annum.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to Advanced Radiology pre- authorisation, managed care protocols and processes. • Specific authorisation is required for Angiography, CT scans,

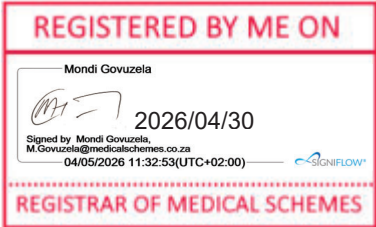
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				MDCT, Coronary Angiography, MUGA scans PET scans, MRI scans and Radio-isotope studies.
C10	Mental Health Consultations, assessments, treatment and counselling by Family Practitioners, Psychiatrists and Psychologists.	100% of Scheme Rate, subject to PMBs.	Subject to: • Limit of R24 746 per family per annum, shared between B18: Mental Health and C10: Mental Health; • Sub-limit of R7 338 for Out-of-Hospital Psychologist consultations; • Further, shared sub-limit with B18:	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to managed care protocols and processes. • If Out-of-Hospital treatment is offered as alternative to hospitalisation, In-Hospital benefits (B18) shall apply.

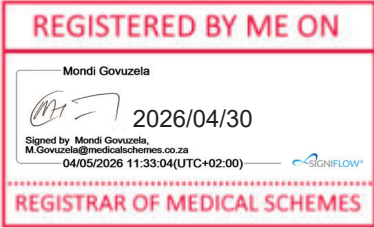
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			Mental Health of R2 879 per family per annum for services by Educational and Industrial Psychologists; and • Limit of one (1) individual Psychologist consultation and one (1) group Psychologist consultation per day.	
C11	Medical and Surgical Appliances and Prostheses Includes:	100% of Scheme Rate, subject to PMBs.	All medical and surgical appliances and prostheses (save for	• All limits are subject to A: Statutory Prescribed

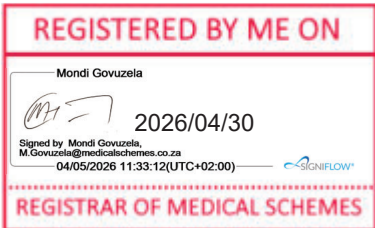
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
	1. Hearing Aids; 2. Wheelchairs; 3. Mobility Scooters; 4. Oxygen Cylinders; 5. Pulse Oximeters; 6. Nebulizers; 7. Positive Airway Pressure (PAP) Devices, i.e. Continuous Positive Airway Pressure (CPAP), Auto-adjusting Positive Airway Pressure (APAP), Bilevel Positive Airway Pressure (BIPAP) and Variable Positive Airway Pressure (VPAP) Devices; 8. Glucometers; 9. Colostomy Kits; 10. Diabetic Equipment;		Continuous Glucose Monitors (CGM) and Insulin Pumps): Subject to: - Shared limit with B14: Prostheses of R56 131 per family per annum for Medical and Surgical Appliances and Prostheses generally; and - Sub-limit of R21 901 per family per annum for C:11 Medical and Surgical Appliances and Prosthesis, with further, shared sub-	Minimum Benefits ("PMBs"). - Subject to managed care protocols and processes. - Diabetic accessories and appliances, other than Glucometers, Continuous Glucose Monitors (CGM) and Insulin Pumps, to be pre-authorised and claimed from the chronic medication benefit (C8.2). - Foot orthotics and prosthetics, subject to Formulary, managed

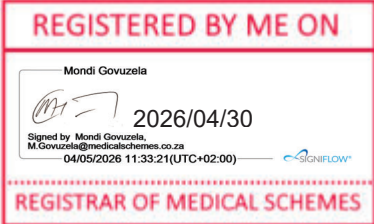
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
	11. Foot Orthotics; 12. External Prostheses; 13. Compression Stockings; 14. Continuous Glucose Monitors (CGM); and 15. Insulin Pumps. Applicable In- and Out-of-Hospital. 		limits with B14: Prostheses of: - o R6 164 per Beneficiary per annum for foot orthotics and prosthetics, with a sub-limit of R1 761 per Beneficiary per annum for orthotic shoes, foot/shoe/ankle inserts and levelers; - o R701 for crutches per Beneficiary per annum; - o One (1) wheelchair of up to R7 716 per	care protocols and processes. • The Scheme has the right to obtain competitive quotes.

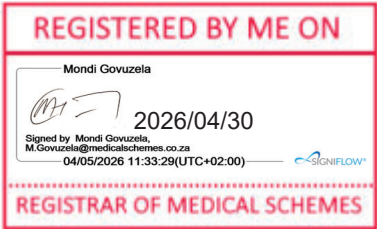
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			Beneficiary every thirty-six (36) months of month of receipt of wheelchair; - One (1) unilateral hearing aid, or one (1) pair of bilateral hearing aids, of up to R11 223 per hearing aid per Beneficiary every thirty-six (36) months of month of receipt of hearing aid(s); - One (1) CPAP device (including accessories) of up to	

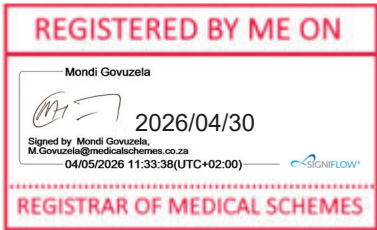
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			R13 328 per Beneficiary every thirty-six (36) months of month of receipt of device; or one (1) APAP, BIPAP or VPAP device (including accessories) of up to R19 623 per Beneficiary every thirty-six (36) months of month of receipt of device; however, if a device is clinically indicated, but not prescribed by the Scheme's managed	

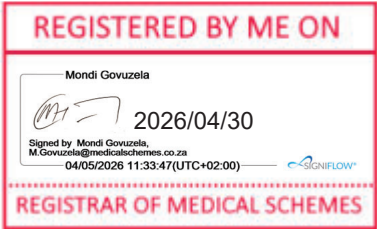
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			care protocols and processes, the device shall be funded in accordance with the limits applicable to CPAP devices; - o Three (3) pairs of compression stockings of up to R584 per pair per Beneficiary per annum; - o One (1) Pulse Oximeter of up to R467 per Family per annum; and	

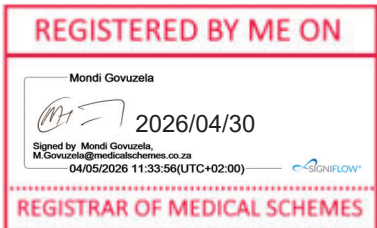
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			- One (1) knee and one (1) back brace of up to R3 499 per brace per Beneficiary per annum. Continuous Glucose Monitors (CGM) and Insulin Pumps: Subject to: - Limit of R59 531 per family per annum for devices (excluding consumables, which are provided for in the chronic medication benefit (C8.2));	

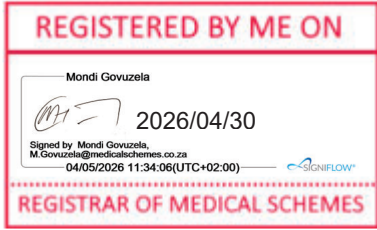
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			• Sub-limit of one (1) device per Beneficiary every sixty (60) months of month of receipt of device; • Limited to type one (1) diabetics aged below nineteen (19) years.	
C12	Renal Dialysis Out-of-Hospital	100% of cost, but subject to PMB legislation.	Limited to PMBs.	• All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). • Subject to Renal Dialysis pre-authorisation, managed

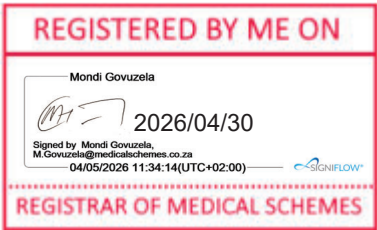
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				care protocols and processes. • Subject to use of Renal Dialysis Network DSP; failing which, a co-payment of 30% per event shall apply in accordance with Network rules. • Includes materials and related pathology tests.
C13	Screening Services Including: Cholesterol, Bone Density, Pap Smear, Prostate Specific Antigen, Glaucoma, TB, Syphilis, Chlamydia, Gonorrhoea, Infant Hearing,	100% of Scheme Rate.	Payable from Risk. All screenings are limited to one (1) of each per annum, unless otherwise indicated herein.	• All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”).

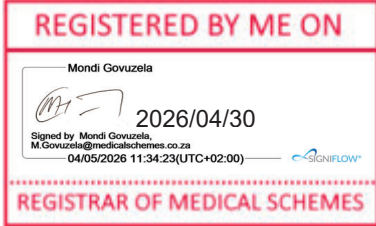
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
	Childhood Hearing, Childhood Optometry, Glucose, Occult Blood, Thyrotropin (TSH) for Neonatal Hypothyroidism, Mammogram, and other screenings according to evidence-based standard practice. 			• All subject to managed care protocols and processes. • Pap Smears include liquid-based cytology and Hr-HPV DNA tests. • Infant Hearing Screening for Child Dependants under the age of one (1) year. • Childhood Hearing Screening for Child Dependants up to and including the age of seven (7) years. • Neonatal Hypothyroidism screening test - TSH

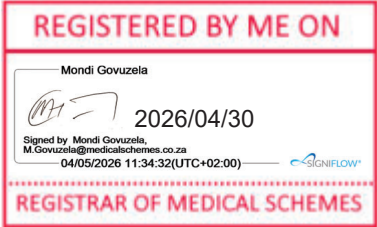
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				(Thyrotropin) - tariff 4507 only. Includes screening services provided in pharmacies.
C14	Preventative Care Services Includes: 1. All Vaccinations; 2. Dental Sealants; and 3. Dental Polishing.	100% of Scheme Rate.	Paid from Risk. Influenza Vaccinations: Limited to one (1) course per Beneficiary per annum. Pneumococcal Vaccinations: Limited to one (1) course per Beneficiary every five (5) years for Beneficiaries at risk in accordance with	- All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). - Subject to managed care protocols and processes. - Includes preventative care services, i.e. vaccinations, provided in pharmacies.

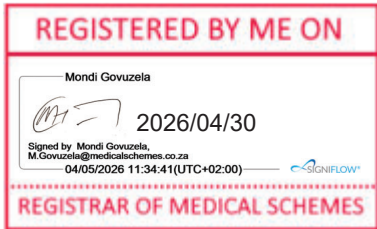
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			managed care protocols. HPV Vaccinations: Limited to one (1) course per female Beneficiary per lifetime. Other Vaccinations: Limited to R950 per Beneficiary per annum. Dental Sealants: Limited to Beneficiaries under 18 years of age, and subject to use of a Network provider. Dental Polishing: Limited to Beneficiaries between the ages of three (3) and nine (9)	

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			years (both inclusive). Service may be rendered by a Network or Non-Network provider.	
C15	HIV Infection, Acquired Immune Deficiency Syndrome and Related Illness 	100% of cost, but subject to PMB legislation.	Limited to PMBs.	• All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). • Subject to managed care protocols and processes. • Pre-exposure prophylaxis included for high-risk Beneficiaries, subject to managed care protocols and processes.

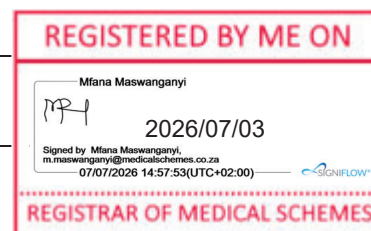
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
C16	Infertility 	100% of cost, but subject to PMB legislation.	Limited to PMBs.	- All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). - Subject to pre-authorisation of facility and service(s), managed care protocols and processes, and use of a DSP (i.e. State or Network) facility; failing which, the Scheme shall not be liable to fund the first R15 000 of the other facility's bill.
C17	Emergency Assistance (Road and Air)	100% of cost, but subject to PMB legislation.	Unlimited, but subject to PMB legislation.	All limits are subject to A: Statutory Prescribed

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				Minimum Benefits (“PMBs”). • Subject to use of Emergency Medical Services DSP, and managed care protocols and processes.
C18	Circumcision	100% Scheme Rate.	Global fee of R1 994 per Beneficiary per annum. Refer to Annexure E (Exclusions and Limitations) of GEMS Rules.	• All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). • Subject to pre-authorisation of facility and services, and managed care protocols and processes. • Limit applies to:

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				○ All related costs, e.g. consultations, medication etc.; and ○ All post-op care within a month of procedure. ● In-Hospital benefits shall apply for circumcisions performed in practitioners' rooms.
C19	Chronic Back and Neck Rehabilitation Programme	Negotiated Rate.	Paid from Risk, but limited to Chronic Back and Neck Rehabilitation Programme benefits.	● All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). ● Subject to registration on Chronic Back and Neck Rehabilitation Programme, and

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				managed care protocols and processes. Out-of-Hospital benefits (excluding this benefit C19: Chronic Back and Neck Rehabilitation Programme) shall apply, if not registered on the Chronic Back and Neck Rehabilitation Programme.

Legend:	
Scheme Rate	See Rule 4.38 of the GEMS Rules.
CDL	Chronic Disease List
Chronic DSP	Chronic Designated Service Provider. Subject to Annexure G of the GEMS Rules.
DTP	Diagnosis and Treatment Pairs as provided for in the Regulations to the Medical Schemes Act.
PDF	Professional Dispensing Fee
PMB	Prescribed Minimum Benefit
SEP	Single Exit Price
TTO	Treatment Taken Out



Healthcare services or claims that do not meet the Scheme's (including its managed healthcare programmes') clinical protocol or billing requirements in accordance with Regulation 5 to the Medical Scheme Act 131 of 1998, shall be excluded, provided that such protocols are in accordance with internationally accepted evidence-based treatment guidelines and protocols.