gems
Government Employees Medical Scheme

2025 MEMBER GUIDE

What a **GEM** worth sharing:

Healthcare designed to meet the needs of the South African family!

DISCOVER THE BRILLIANCE OF GEMS

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WELCOME

Thank you for choosing and trusting GEMS to care for your healthcare needs in 2025. As a Scheme, we are passionate about finding new ways to deliver increased member value and provide you and your family access to quality healthcare services.

This guide explains how to utilise and access your benefits and the various available services.

Please note that this is a summary of the Scheme's benefits and rules, not a replacement of the registered rules. If there is a conflict between this guide and the rules, the Scheme Rules registered with the Council for Medical Schemes (CMS) will take precedence. **The Scheme Rules are available at www.gems.gov.za, or you can request a copy by emailing enquiries@gems.gov.za or calling 0800 004 367 (toll-free).**

OUR VISION

An excellent, sustainable and effective medical scheme that drives transformation in the healthcare industry, aligned with the principles of universal healthcare coverage.

OUR MISSION

To provide all members with equitable access to affordable and comprehensive quality healthcare, promoting member well-being.

OUR VALUES

These values guide all representatives of GEMS at all times:

Excellence
Member Value
Integrity
Collaboration
Innovation

Our Benefit Options

We also give you the flexibility to choose between **six options so that you enjoy the benefits that suit you best:**

01

TANZANITE ONE

This is an entry-level network benefit option tailored for level 1- 5 employees, subject to Network GP nomination and Specialist Referral Rules.

On Tanzanite One, you receive coordinated care for improved healthcare outcomes!

02

BERYL

This is an entry-level network benefit option tailored for members with limited healthcare needs.

03

RUBY

This mid-level benefit option is tailored for members with limited to average healthcare needs who wish to enjoy a personal medical savings account.

04

EMERALD VALUE OPTION

This is an efficiency discounted sub-option of Emerald, tailored for members with average to above-average healthcare needs.

05

EMERALD

This high-level traditional option is tailored for members with average to above-average healthcare needs.

06

ONYX

This is a top-level benefit option tailored for members with above-average to extensive healthcare needs.

MANAGING YOUR MEMBERSHIP

Who can be a member of GEMS?

You can join GEMS if you are employed in:

- A National Department and Provincial Administration listed in Schedule 1 of the Public Service Act.
- A Provincial Department listed in Schedule 2 of the Public Service Act.
- Government components listed in Schedule 3 of the Public Service Act.
- Any employer group approved by the Board (a list of these employers is available in Annexure A of the Scheme Rules).

You cannot join GEMS if you are employed by:

- The South African National Defence Force (SANDF) under the Defence Act.
- The National Intelligence Agency (NIA).
- The South African Secret Service (SASS)
- Uniformed members of the South African Police Service (SAPS).
- Any department where the conditions of service do not allow you to join GEMS.
- Call GEMS to determine your eligbility or speak to your HR Offcer

Membership cards and certificates

- When a main member joins the Scheme, changes their benefit option, removes or adds a dependant, they receive a membership card and certificate (also available virtually on the GEMS Member App). Each registered adult dependant is also given a card (i.e., a dependant older than 21 years of age).
- You and the registered dependants listed on the back of your membership card are the only people who can use the card to claim benefits. Giving your membership card to someone who is not your registered dependant and having them use it to claim benefits is considered fraud.

- If you resign, you can no longer use the membership card.
- Using the card after your resignation is considered fraud.
- Please include your membership number in all correspondence with the Scheme so we can assist you as quickly as possible.
- Remember to show your membership card when you visit your doctor, dentist, pharmacist, specialist, and all other allied healthcare service providers (listed in your Benefits Guide).

To learn more about your membership cards and certificates, visit www.gems.gov.za and read Rule 10 of the main body of the Scheme Rules. You can also request a copy by sending an email to **enquiries@gems.gov.za or by calling 0800 004 367 (toll-free).**

Why is it important to manage your GEMS membership?

To get the most out of your GEMS membership, make sure you understand and adhere to the Scheme Rules and Procedures. To learn more about your membership, visit www.gems.gov.za and read Rule 10 of the Scheme Rules. You can also request a copy by sending an email to **enquiries@gems.gov.za or by calling 0800 004 367 (toll-free).**

Protecting your personal information

The Protection of Personal Information Act 4 of 2013 (POPIA), which came into effect on 1 July 2021, provides a guideline of the minimum standards regarding the accessing and processing of personal data. The purpose of POPIA is to protect your right to privacy and to regulate how personal information is processed. GEMS adheres to the highest standards in terms of safeguarding the personal data of our members, and only relevant personal information is collected for our operations to provide you with excellent service.

Help us to protect your personal information

GEMS aims to help public service employees and their families get the best possible healthcare at the most affordable rate. We must, therefore, comply with POPIA by verifying member details in every interaction we have with you:

- When you contact the Call Centre, you will be asked verification questions and will only be assisted once your identity is validated.
- During face-to-face interactions, for example, when you visit a Walk-in Centre, you will need to produce valid physical proof of identification.
- For third party enquiries, you need to complete and submit the Authorisation to Disclose Information Form, authorising GEMS to disclose personal information to a third party. This form can be downloaded from our website at www.gems.gov.za.

Change of banking details: FICA

To protect your benefits and ensure efficient claim refunding, please send us the following documents if your banking information needs to be updated:

- A copy of your Identity Document (ID)/Smart ID with the commissioner of oaths stamp (not older than 3 months).
- A bank account statement, or a signed or stamped bank letter (not older than 3 months).
- Proof of address, such as a utility bill, a signed bank statement, or a certified affidavit confirming proof of address (not older than 3 months).

Any documents older than 3 months will be rejected and may potentially delay your refund. It is crucial to submit these documents, as GEMS prescribes to the Financial Intelligence Centre Act 38 of 2001(FICA), which combats money theft and fraud by assisting in the identification of individuals who engage in such illegal activities.

Stay informed:

Remember to update your contact details so that we can keep you informed with important healthcare and membership information.

Let us know if:

- You retire;
- You want to add or remove dependants;
- The main member or any of the registered dependants passes away;
- The main member resigns from the Public Service or a GEMS participating employer; or
- You or your dependants will be residing outside the borders of South Africa, temporarily or permanently.

Let us know as soon as any of the following details change:

- Email address, telephone number or other contact details.
- Banking details.
- Marital status.
- Change in employment.
- Monthly income.

To update your details you can:

- Dial *134*20018# and follow the prompts.
- Call the GEMS Call Centre on 0800 004 367 (toll-free).
- Send an email to enquiries@gems.gov.za.
- Send a fax to 0861 00 4367.
- Visit a GEMS Walk-in Centre or advising Client Liaison Officers (CLOs) at member engagement events.

HOW TO REGISTER YOUR DEPENDANTS

A completed GEMS application form may be submitted via email to newapps@gems.gov.za, faxed to 0861 00 4367, posted to GEMS at Private Bag X782, Cape Town 8000, or dropped off at one of the GEMS Walk-in Centres. You can also complete an electronic application via **https://eforms.gems.gov.za/JoinGems.**

The following supporting documents are required upon submission of a membership application:

For member:

- Clear copy of either Green ID book/Smart ID (both sides) or valid Passport.
- Latest salary advice or letter of appointment (not older than 3 months).
- Bank statement with stamp (not older than 3 months).
- Previous medical aid certificate with resignation date (if applicable).

For each dependant:

- Clear copy of either Green ID book/Smart ID (both sides) or Birth Certificate/SA Passport.
- Previous medical aid certificate with resignation date (if applicable).

For Pensioner:

- Clear copy of either Green ID book/Smart ID (both sides) or valid Passport.
- The Z583 Form (certified by Commissioner of Oaths).
- Previous medical aid certificate with resignation date (if applicable).

ABOUT YOUR DEPENDANTS

Registration of your dependants

You and your dependants are always at the heart of all our efforts. The following family members may qualify as your dependants:

- Husband, wife, or partner involved with the main member.
- Ex-husband or ex-wife, if required by a divorce settlement.

Biological, adopted, step, or foster children. Child dependants are persons:

- Under the age of 21
- Under the age of 28 and registered as a bona fide student at an educational institution recognised as such by the Board, within South Africa or any other educational institution abroad; or
- Dependent on the main member and deemed by the Board to be permanently disabled, irrespective of age.

- Parents, parents-in-law, stepparents, step-parents-in-law, grandparents, and grandparents-in-law, if they are factually dependent on the main member.
- Grandchildren and great-grandchildren if they are factually dependent on the main member.
- Siblings (brothers and sisters), half-siblings, step- siblings, and in-law siblings, if they are factually dependent on the main member.

If the child is dependent due to mental or physical disability, we need:

- Proof of disability from a medical practitioner (medical assessment report to be completed, signed, and stamped by a medical practitioner).
- A declaration letter, email or telephone call from the main member confirming factual dependency and that the child is not in a state institution.

If the child dependant is neither a student nor disabled, we need:

- A declaration letter, email or telephone call from the main member confirming factual dependency.
- Important to note: adult rates will be applicable in this instance.

Parents, parents-in-law, grandparents, and grandparents-in-law

- A declaration letter, email, or telephone call from the main member confirming the factual dependency of the dependants.

Grandchildren and great-grandchildren

- A declaration letter, email, or telephone call from the main member confirming the factual dependency of the dependants.

Siblings (brothers or sisters), half-siblings, stepsiblings, and siblings in-law

- A declaration letter, email or telephone call from the main member confirming factual dependency of the sibling on the main member.

Nephews and nieces (including in-laws)

A declaration letter, email, or telephone call from the main member confirming the factual dependency of nephews and nieces on the main member.

Special dependants (where the member is liable for family care and support)

The Addition of Dependants Form must be completed by the main member and a copy of the dependant's ID must be submitted to the Scheme. A declaration letter, email or telephone call from the main member confirming factual dependency of the special

Registering your newborn or newly adopted child.

Send the Scheme a completed Newborn Registration Form and a copy of the child's birth certificate within 60 days of the birth so that they can be registered as a dependant on the Scheme from the date of birth. If your child is adopted or is newly adopted, please provide the final adoption letter. We will then cover any medical expenses incurred as a result of the newborn's birth (subject to available benefits). If the surname of your newborn differs from yours, you must provide the Scheme with a declaration letter, email, or phone call confirming that the child is yours.

You can download the Newborn Registration Form from our website by visiting www.gems.gov.za.

When the baby is registered with the Scheme within 90 days of the birth or adoption, the full monthly contribution is due from the month of birth or adoption, regardless of the newborn's registration date. This ensures that the newborn and/or adopted child has medical aid coverage from the date of birth or adoption. If the newborn/adopted baby is registered to the Scheme after 60 days, medical coverage will begin on the first day of the following month from the date of registration. The newborn will be subjected to underwriting after 90 days under the Medical Scheme Act.

Yearly review of dependants

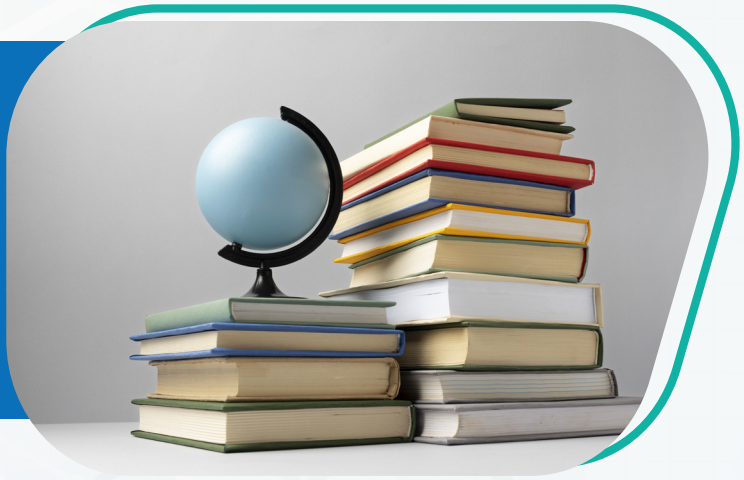
Every year, the Scheme determines whether dependants are still eligible to receive benefits under the Scheme Rules. This means that each year, main members must provide us with proof of factual dependency for all dependants aged 21 to 28. For disabled dependants, the main member only needs to provide supporting documents to the Scheme once.

Eligibility review – implementation of GEMS Scheme Rule 4.9.5

- Rule 4.9.5 allows for students studying short courses at any time during the year to be registered at the child rate. Previously, you could only register your dependant for child rates if they studied as a full-time student.
- Rule 4.9.5 means we will review the eligibility of the dependant throughout the year, triggered by their study completion dates.
- The new short-course rule allows the main member to pay a child rate for a dependant for the duration of their registration on a short course. The child rate will return to an adult rate after the completion date of the short course.
- For example, if the dependant student is studying a three-month diploma course at an approved educational institution, the main member will be required to pay a child rate during the three-month course period.

AGE	RATES TO BE PAID	REVIEW PERIOD
Under 21 years old.	You pay child rates.	When child turns 21.
21 years and older, but under 28 years.	If the dependant is a student, you pay child rates as long as you have provided proof that the student is studying at a recognised educational institution. You also need to provide a declaration letter, email or telephone call stating factual dependency. **Note:** If the dependant is not a student, but is factually dependent on the main member, they may continue as a dependant at adult contribution rates, if all relevant documents are submitted.	Documents must be provided before the end of March every year for full-time students. Students studying short courses must provide proof of study at the time they register for said courses.

Students studying abroad may be dependants while studying but cannot claim benefits while abroad as they are not considered to be "ordinarily residing in SA." According to GEMS Scheme Rule 6.2, "Membership to the Scheme is limited to those Members and their Dependants who are ordinarily resident within the Republic of South Africa, or who are stationed abroad on or due to instructions, requirements, or obligations of the Member's Employer, or who are studying



Why it is important to send your documents to us on time

It is essential that the Scheme receives all documentation and supporting documents requested in the eligibility review letters for your dependant to continue receiving benefits. If the documents for your newborn are provided more than 60 days after the birth, the dependant will not be covered by the Scheme from the date of birth. This means you will have to pay the hospital costs for the newborn out of your pocket.

International Eligibility

Membership to the Scheme is only for members residing within the borders of the Republic of South Africa. Certain groups of members who are stationed abroad due to the nature of employment and certain retired members who left government service prior to 1992 are exempt from this requirement.

Members re-joining the Scheme with outstanding debt

Members who have, during a previous period of membership, left the Scheme with debt owing will be required to make payment or enter a payment arrangement with the Scheme before a new membership period is effected.

Continuation of membership

The dependants of a GEMS member can continue with the membership to the Scheme when the main member is deceased without a break in medical aid cover. The surviving dependants will be required to nominate a dependant who will be elevated to the main member and, upon payment of contributions, can continue with their membership, i.e. from the first of the month following the month of main member's passing.

WAITING PERIODS

Waiting periods are a risk management tool that medical schemes implement as permitted by the Medical Schemes Act.

The risk profile of new members or beneficiaries is assessed to determine whether waiting periods should be imposed with a view to reduce GEMS' exposure to anti-selective behaviour and non-disclosure.

A waiting period is a period during which a beneficiary is liable for contributions without having access to all or certain benefits.

There are two types of waiting periods that GEMS may apply.

These are:

- A General Waiting Period (GWP) of up to 3 months; and/or
- A Condition-Specific Waiting Period (CSWP) of up to 12 months.

A GWP is a period in which a beneficiary is not entitled to claim any benefits or, in certain circumstances, entitled to claims only in respect of Prescribed Minimum Benefit (PMB) conditions.

A CSWP is a period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 12-month period prior to the application for membership with the Scheme. There is a monitoring process in place to identify pre-existing conditions that were not disclosed by the member on the application for membership. An investigation will be conducted if non-disclosure is suspected, and this can happen at any time during the admission or claims process.
If it is found that the beneficiary failed to disclose a pre-existing condition, GEMS will apply a CSWP for that condition. A membership certificate stating the CSWP will be sent to the main member. GEMS will not cover any costs associated with the conditions for the period shown in the membership certificate. The claims that may have been paid may also be reversed if they were paid prior to the outcome of the non-disclosure investigation. This means the member would have to pay for the reversed claims.
GEMS has a process for members to make an informed decision regarding their underwriting status by accepting or rejecting waiting periods imposed on their membership by signing an acceptance letter or using the USSD functionality. An acceptance letter with the imposed waiting periods is sent to the member to review and sign the acceptance of the imposed waiting periods and finalise the application process.

The waiting period acceptance should be returned within 7 days using one of the following channels:

- USSD functionality by dialling *134*20018#
- Post to Private Bag X782, Cape Town 8000
- Dropped off at one of the GEMS Walk-in Centres

Waiting periods protect GEMS and its members from abuse by persons who join GEMS only to claim for certain, usually pre-existing, medical conditions but have no intention of contributing fairly after their claims have been paid and then resign from the Scheme.

COST OF MEMBERSHIP

To make healthcare more affordable for you, GEMS brings you the best possible benefits to suit your healthcare needs and your pocket.

These are the monthly contributions (how much you pay each month to be a member of GEMS) for 2025. They do not show how much you will pay when the employer subsidy is included. If you qualify for a subsidy, the employer will pay a part of the contribution, and you will pay the balance. Read about how the subsidy works on page 18.

TANZANITE ONE OPTION			
Salary	**Member contribution**	**Adult contribution**	**Child contribution**
R0 - R10 989.00	R1 546	R1 221	R666
R10 989.01 - R15 421.00	R1 620	R1 298	R718
R15 421.01 - R26 418.00	R1 824	R1 444	R804
R26 418.01 +	R2 134	R1 806	R1 022

BERYL OPTION			
Salary	**Member contribution**	**Adult contribution**	**Child contribution**
R0 - R10 989.00	R1 744	R1 740	R979
R10 989.01 - R15 421.00	R1 893	R1 878	R1 080
R15 421.01 - R26 418.00	R2 185	R2 185	R1 226
R26 418.01 +	R2 624	R2 624	R1 489

Please note: 20% of contributions on the Ruby Option will go towards the Personal Medical Savings Account.

RUBY OPTION			
Salary	**Member contribution**	**Adult contribution**	**Child contribution**
R0 - R16 549.00	R3 605	R2 705	R1 395
R16 549.01 - R28 581.00	R4 015	R3 015	R1 565
R28 581.01 +	R4 445	R3 350	R1 725

EMERALD VALUE OPTION			
Salary	**Member contribution**	**Adult contribution**	**Child contribution**
R0 - R16 549.00	R3 374	R2 578	R1 254
R16 549.01 - R28 581.00	R3 734	R2 894	R1 407
R28 581.01 +	R4 183	R3 216	R1 567

EMERALD OPTION			
Salary	**Member contribution**	**Adult contribution**	**Child contribution**
R0 - R16 549.00	R4 030	R3 070	R1 496
R16 549.01 - R28 581.00	R4 460	R3 448	R1 676
R28 581.01 +	R5 001	R3 834	R1 870

ONYX OPTION			
Salary	**Member contribution**	**Adult contribution**	**Child contribution**
R0 - R16 549.00	R6 988	R5 350	R2 101
R16 549.01 - R35 263.00	R7 272	R5 537	R2 283
R35 263.01 +	R7 852	R6 035	R2 547

1. **Premium Penalties for Persons Joining Late in Life, Effective 1 June 2025.**

1.1 At the discretion of the Board, premium penalties may be applied to a late joiner.

1.2 Such penalties shall be applied only to that portion of the contribution relative to the late joiner and shall not apply to the Personal Medical Savings Account (PMSA) contribution.

1.3 A late joiner penalty shall not exceed the following bands:

Penalty Bands	Maximum Penalty
1 - 4 years	0.05 x contribution
5 - 14 years	0.25 x contribution
15 - 24 years	0.50 x contribution
25+ years	0.75 x contribution

1.4 **The following formula shall be applied to determine the applicable penalty band:**

A = B minus (35 + C) where:
A = number of years to determine the appropriate penalty band
B = age of late joiner at the time of application
C = number of years of credible coverage which can be demonstrated

1.5 Should a late joiner penalty been imposed, and evidence of credible coverage is produced thereafter, the penalty shall be recalculated, and such revised penalty shall be applied from the time that such evidence was provided.

1.6 If an applicant is unable to provide documentary proof to substantiate periods of creditable coverage, he/she shall be entitled to produce an affidavit declaring that reasonable effort to obtain documentary evidence of such periods of credible coverage was unsuccessful.

HOW THE SUBSIDY WORKS

Approved medical scheme subsidy

One of our goals as GEMS is to keep member contributions affordable, and the medical scheme subsidy provided by your employer plays an important role in this. Please consult your employer for information on the subsidy and how it applies to you as an individual. Employees on salary levels 1 to 5 on the Tanzanite One option will continue to be fully subsidised, up to the maximum amounts specified below. In-service GEMS employees will receive a 75% subsidy on their total contribution, up to the maximum amount shown below.

Please keep in mind that your subsidy eligibility is determined by your employment conditions; therefore, your employer will be able to confirm the subsidy you qualify for. If you add more dependants and have exhausted your employer's maximum subsidy, you will be required to pay the amount not covered by the subsidy as a member contribution.

The subsidy policy for pensioners is as follows:

- Pensioner members on GEMS will receive 75% of their monthly contribution as a subsidy up to a maximum of R1 918 for a member without dependants.
- Pensioner members will receive 75% of their monthly contribution as a subsidy up to a maximum of R3 836 for a member with dependants.

Please note that the Government Pensions Administration Agency (GPAA) determines the eligibility for pensioner members. If you have any questions about your subsidy, you may discuss them with the GPAA through their contact number: **(012) 319 1911.**

Please note: Pensioner members who were on salary levels 1 to 5 and on the Tanzanite One option while they were in employment (in-service), and retire on the same option, will now continue to receive a 100% subsidy to a maximum of R3 836.

One of our objectives is to ensure that member contributions remain affordable.

Please visit the contribution calculator on our website at **www.gems.gov.za.** The calculator will help you work out your monthly contributions.

Employer subsidy for in-service employees effective from 1 January 2025.

Please note that the subsidy is calculated as 75% of the total contributions up to a maximum as indicated in below table:

MEMBER PROFILE	1 JANUARY 2024 MONTHLY EMPLOYER SUBSIDY	1 JANUARY 2025 MONTHLY EMPLOYER SUBSIDY
Single Principal Member	R1 810	R1 918
Principal Member with one dependant	R3 620	R3 836
Principal Member with two dependants	R4 726	R5 008
Principal Member with three dependants	R5 832	R6 180
Principal Member with four dependants	R6 938	R7 352

GPAA subsidy for retired employees effective from 1 January 2025.

Please note that the subsidy is calculated as 75% of the total contributions up to a maximum as indicated in below table:

MEMBER PROFILE	MAXIMUM EMPLOYER MONTHLY SUBSIDY	MAXIMUM EMPLOYER MONTHLY SUBSIDY FOR TANZANITE ONE OPTION SALARY LEVEL 1-5
Principal Member without a dependant	**R1 918**	**R1 918** or limited to Tanzanite One contribution of a single member.
Member plus dependant/s	**R3 836***	**R3 836**** or limited to Tanzanite One contribution of member plus dependant/s.

*Maximum Post-Retirement Medical Subsidy calculated at a maximum of a principal member plus dependant/s.

**Maximum Post-Retirement Medical Subsidy calculated at a maximum of a principal member plus dependant/s for former employees on salary levels 1 to 5 who belonged to the Tanzanite One option.

NOTE: Your subsidy is determined by your employer and not by GEMS.

Contribution statements

Each quarter, we send a contribution statement to all members. Members who owe GEMS money will receive a monthly contribution statement outlining their monthly contribution payments and any money owed to GEMS. This statement helps you ensure that your contributions are always up to date.

Managing arrear contributions

You might be behind in your payments to GEMS if:

- Your monthly contribution costs have not been deducted from your salary by your employer. This can happen to new members if their membership start date is captured after the PERSAL cut-off date for that month's deductions or if you switch departments;
- You added a dependant, but the additional contribution for the new dependant was not applied to the contribution payment on time ;and
- Your employment contract ended, and your new contract was not active when the next payment was due.

We will send you a letter confirming the amount you owe the Scheme. If you need help with paying the contributions you owe, please contact the Scheme, or ask your HR Department to help you with the repayment terms.

Different types of debts, what causes it and how to prevent it.

TYPE OF DEBT	CAUSES	PREVENTION
Change of employment or Bureau	Transfers	Provide the relevant letter of appointment to **premiums@gems.gov.za** to adjust your contributions accordingly.
Employer/Persal clawback (Code 39)	The member's termination date is backdated.	Inform GEMS via **premiums@gems.gov.za** when your employment has been or will be terminated.
Retirement	Pensioners are responsible for the full contribution while awaiting GPAA subsidy approval.	Submit your GPAA approval letter to **premiums@gems.gov.za.** You will be refunded when subsidy is applied and payments received from GPAA.
Short-payment of contributions for dependants.	Dependants who are registered after payroll cut-off date and over- age dependants who are still studying and proof has not been submitted to GEMS.	Notify your employer or relevant department as soon as you register a dependant so that your contributions are adjusted on time via Persal. Provide the relevant documents regarding your dependant's proof of study to GEMS.

Note: Members must make payments towards their arrears using their membership number as a reference.

PERSONAL MEDICAL SAVINGS ACCOUNT

A Personal Medical Savings Account (PMSA) is only available to our Ruby option members. The PMSA is a savings account in the name of the main member that receives 20% of the total contribution. The amount allocated to the PMSA is determined by the main member's salary and the number of beneficiaries. The PMSA covers out-of-hospital and daily medical expenses. When the PMSA is exhausted, out-of-hospital claims will be paid from the limited Block Benefit, which includes Family Practitioner services, Pathology and Medical Technology, Optical Services, Allied Health Services, Other Professional Health Services, Physiotherapy, Audiology, Occupational Therapy, and Speech Therapy.

Funds in the PMSA that are not used during the year will be carried over to the following year or paid out to you (or to your new medical scheme) five months after you have terminated your membership or changed to a non-medical savings account option. Please keep in mind that this payment is taxable. If a refund is owed to you, make sure the Scheme has your most recent banking information.

PMSA statements

Ruby members will receive an annual PMSA statement. This statement will show all transactions and entries made on your savings account and balances at each month-end. This is a separate statement from the normal claims and contribution statements sent quarterly. This statement is distributed to Ruby members once a year and will be distributed when the IT3 (b) statements and tax certificates are issued. Note that you will not earn interest on your PMSA.

A Personal Medical Savings Account (PMSA) only applies to members who select the Ruby option.

PRESCRIBED MINIMUM BENEFITS

Prescribed Minimum Benefits (PMBs) are minimum benefits that GEMS provides in accordance with the Medical Schemes Act.

GEMS is required to offer benefits for the diagnosis, treatment, and care of the legally specified medical conditions, including:

- A list of 271 medical conditions (the Diagnostic Treatment Pairs).
- Any emergency medical condition.
- 26 chronic conditions that are listed on the Chronic Disease List (CDL) and are provided for in the Regulations to the Medical Schemes Act.

The Council for Medical Schemes website (https://www.medicalschemes.co.za/resources/pmb/) provides more information on PMBs, the list of Diagnostic Treatment Pairs, and the Chronic Disease List.

- Qualifying for PMBs is not only based on the condition or diagnosis (ICD-10 code) but also on the treatment type provided by the healthcare provider. The treatment must be in line with what is prescribed in the Medical Schemes Act Regulations. If the treatment provided is not what is written in the Regulations, it cannot be claimed as a PMB.

- PMBs will first be covered from your day-to-day available benefits. Once these benefits have been depleted, the Scheme will continue to pay for PMBs above the benefits.
- PMBs may not be covered from your Personal Medical Savings Account (PMSA) if you are on the Ruby option.
- Codes used by healthcare providers to identify the condition (ICD-10 code) and the treatment given (Tariff code or NAPPI code) are required to ensure GEMS identifies and pays PMBs correctly.
- Please remind your healthcare provider to use the relevant ICD 10 codes on all claims to ensure that your claim is processed correctly. Read more about submitting claims to the Scheme on pages 34 to 41.

- Healthcare providers who treat you for a PMB condition while you are in hospital should include the hospital pre-authorisation number when they claim. It is not always possible for the Scheme or your healthcare provider to know the diagnosis or treatment at the time when authorisation is obtained. In such situations, more information may be required from your healthcare provider after the claim has been submitted, for GEMS to process the claim correctly as PMB.
- GEMS uses measures such as pre-authorisation, formularies, and Designated Service Providers (DSPs) to manage the costs of PMB care.
- If a member or healthcare provider does not follow the processes with respect to these measures, claims may not be paid as PMBs. This means you may be liable for part of the amount of the claim.

What is a Designated Service Provider (DSP)?

A DSP is a healthcare provider or group of providers who have been selected and have a contract with GEMS to provide members with the diagnosis, treatment, and care in respect of medical conditions, including PMB conditions according to an agreed fee schedule. GEMS has selected the following DSPs for PMB care:

- Hospitals: The State and the hospitals included in the GEMS Hospital Network (for Tanzanite one and Emerald value options) are GEMS' DSPs for the treatment of in-hospital PMBs.
- Chronic medicine DSPs: Members should use a GEMS Medicine Provider Network Pharmacy or a Chronic Medicine Courier Pharmacy to obtain their authorised chronic medicine, including medicine for HIV.

- All chronic medicine (even if it is on separate prescriptions) must be obtained from your allocated pharmacy. If you use a pharmacy that is not on the Pharmacy Network (or a Network Pharmacy to which you are not allocated) to obtain your chronic medicine, you may have to make a 30% co-payment out of your own pocket.

- Members may choose to be allocated to either the GEMS Courier Pharmacies or any Network Pharmacy within 10 kilometres of their workplace or home as their chronic medicine DSP. Also, refer to 'How to avoid co-payments' on page 26 or visit www.gems.gov.za.
- Members are required to remain with the pharmacy they have chosen for a period of 6 months, which is in line with the 6-month prescription validity cycle. Please contact us on 0800 004 367 (toll-free) for assistance in selecting or changing your choice of DSP pharmacy.

Note: For Oncology patients, the Oncology DSP is not always the General Chronic DSP. To verify your Oncology DSP, **call 0800 004 367 (toll-free)** and select the Oncology option.

There is an allowance for one non-nominated pharmacy claim per year. This enables chronic registered beneficiaries to obtain their chronic medicine from any pharmacy in South Africa.

Using non-DSPs

If you choose to use a healthcare provider other than the DSP for the in-hospital treatment of a PMB condition, the Scheme may apply a co-payment or limit the rate at which the claim is reimbursed. To determine the reimbursement that should be made for PMB treatment provided, the Scheme will find out whether the beneficiary voluntarily or involuntarily made use of the non-DSP.

Involuntary use means that:

- The service was not available from the DSP or could not be provided without unreasonable delay.
- Immediate (emergency) medical or surgical treatment for a PMB condition was required under circumstances or at locations that precluded the beneficiary from obtaining such treatment from a DSP.
- The DSP was not within a reasonable distance of the beneficiary's ordinary place of business or personal residence.

Except in the case of an emergency medical condition, pre authorisation must be obtained before the voluntary use of a non-DSP. In the case of an emergency hospital admission, a pre-authorisation must be obtained within one working day after the admission; failing to do so a co-payment of R1 000 per admission shall apply.

WHAT GEMS DOES NOT PAY FOR

Every medical scheme has a list of medicines, treatments, and procedures that it does not cover. These are known as scheme exclusions, which help keep medical aid options affordable and sustainable.

Rule 16 and Annexure E of the Scheme Rules detail all Scheme exclusions. You must ensure that the procedures, treatments, or medicines you receive will be paid for before obtaining them, as GEMS will not pay for excluded services or items. GEMS also applies the Medicine Exclusions List (MEL) to all medicine benefits specified in Annexure C of the Scheme Rules. This list can be found on www.gems.gov.za and contains:

- Medicine exclusions on acute and chronic medicine; and
- New products that are still under review.

Examples of exclusions(items that GEMS does not pay for):

- All costs for operations, medicines, treatments, and procedures for cosmetic purposes (cosmetic refers to procedures such as liposuction).
- Holidays taken for recovery.
- Medicines not registered with the South African Health Products Regulatory Authority.
- Toiletries, beauty products, slimming products, homemade remedies, and alternative medicines.
- Household products such as disinfectants, soaps, food, and fitness-related nutritional supplements.
- Treatments by a healthcare provider who is not registered with a recognised professional body or any healthcare facility that is not registered in terms of the law.

- Any medicine, procedure or treatment that is not in line with evidence-based medicine principles and not supported by the Scheme Rules and managed care guidelines.
- Penalties that members incur and must pay to a healthcare provider because they did not keep an appointment.

Remember that even if a treatment is not excluded by the Scheme and is approved or authorised, it will still be denied or paid in part if the Scheme Rate/Tariff and benefit limits are exceeded. Claims may also be denied if they do not adhere to managed care guidelines. You can find the Scheme Rules by visiting www.gems.gov.za, or you can request a copy by calling us on 0800 004 367 (toll-free).

HOW TO AVOID CO-PAYMENTS

There are many ways to avoid co-payments on your medical claims, such as following the recommended GEMS processes.

What is a co-payment?

Co-payments are portions of the cost of procedures or medical services provided by doctors and/or pharmacies that members must pay for out of their pockets. The co-payment can be a certain amount or a percentage of the total bill. These are amounts over and above a set rate that GEMS covers and usually apply to members who do not follow the Scheme Rules or managed care processes or when benefits have been depleted for a service that is not a PMB

How can co-payments be avoided?

Use Designated Service Providers (DSPs)

DSPs are healthcare providers chosen and contracted by GEMS to provide members with medical condition diagnosis, treatment, and care, including PMB conditions. A co-payment will be imposed if a GEMS DSP is not used (where required).

For example, if you receive chronic medicine from a pharmacy other than your designated DSP pharmacy, you will be charged a 30% co-payment, even if the medicine is on the formulary (see more about in-formulary medicines later in this section). However, you are permitted one out-of-network pharmacy visit per benefit year.

How to avoid non-DSP co-payments

Follow these guidelines to avoid non-DSP co-payments:

Tanzanite One	Beryl	Emerald Value
• Obtain your acute and over-the- counter medicines from your network dispensing doctor or from a network pharmacy. • Only consult with your nominated FP (Family Practitioner). You have unlimited nominated FP visits with three non-nominated visits per beneficiary. [A 30% co-payment will apply once the three visits have] been exhausted.] The 16th and subsequent consultation per beneficiary will require pre-authorisation.	• Obtain your acute and over-the-counter medicines from your network dispensing doctor or from a network pharmacy. • Only consult with a GEMS Network FP. You have unlimited network FP visits. Visits to a non-network FP are limited to three visits per family (and subject to limits) and include a 30% co-payment. The 16th and subsequent consultation per beneficiary will require pre-authorisation.	• Only consult with your nominated FP (Family Practitioner). You have un limited nominated FP visits subject to the block benefit. • You may obtain authorisation for three (3) out-of-hospital (OH) non-nominated network FP visits per family per benefit year, with no co-payment. Once the three visits have been exhausted, a 30% co-payment will apply to claims for any additional non-nominated network FP visits, subject to benefits and limits. • non-nominated network FP visits per family per benefit year, with no co-payment. Once the three visits have been exhausted, a 30% co-payment will apply to claims for any additional non-nominated network FP visits, subject to benefits and limits.

Give birth naturally, if possible

An elective caesarean section delivery (in other words, where the caesarean section is by choice and not due to a medical condition or an emergency) will incur a R10 000 co-payment. In addition, if you are required to make use of a Network hospital and choose instead to make use of a non-network facility, you will be liable for a R15 000 non-network co-payment.

Consult healthcare providers on the GEMS Network

GEMS has a network of healthcare providers consisting of Family Practitioners (FPs), Specialists, Pharmacies, Dental Health Practitioners, Optometrists, Renal Dialysis Providers, Hospitals, Emergency Care Practitioners, and Chronic Back and Neck Rehabilitation Providers.
GEMS Network healthcare providers have committed to providing excellent, quality healthcare at Scheme rates and will not charge you any co-payments or additional costs.

If a healthcare provider on the GEMS Network wants you to pay upfront or requests you to pay from your pocket, contact GEMS immediately on 0800 004 367 (toll-free). It is important to report any irregularities relating to GEMS Network healthcare providers to the Scheme.

Consult renal facilities on the GEMS Renal Network

GEMS has contracted a network of Renal Dialysis Providers. If you do not use a provider on the network for chronic renal dialysis subject to authorisation a 30% co-payment will apply.

Use GEMS Hospital Network facilities for Emerald Value and Tanzanite One members

GEMS Hospital Network: Members on the Tanzanite One and Emerald Value plans must use GEMS hospital network facilities. This network includes private hospitals, day clinics, and mental health institutions.

Co-payment for Non-Network Hospitals: If a member is admitted to a non-network hospital, a R15,000 co-payment will be charged to their account. However, there are exceptions:

Medical Emergencies: If the admission is due to a medical emergency, the co-payment may not apply.

Unavailable Services: If the necessary services were unavailable at the nearest network hospital, the co-payment may also be waived.

Exceptions Management Process: Hospital co-payments are reviewed as part of the exceptions management process. Feedback regarding these exceptions will be provided within 2 to 3 working days.

A lists of Network providers is available on the GEMS website at www.gems.gov.za or the member may contact GEMS on 0800 004 367 (toll-free) or enquiries@gems.gov.za. The GEMS walk-in centers can also assist members with locating a GEMS Healthcare Network Provider.

Use in-formulary medicine

GEMS has two medicine formularies:

1. Comprehensive Chronic Formulary

The Comprehensive Chronic Formulary is a list of cost-effective medicines which GEMS pays in full according to the Scheme Rules. If your doctor prescribes medicine that is not on the GEMS Comprehensive Chronic Formulary (medicine list), you will have to pay a 30% out-of-formulary co-payment.

2. The Acute Formulary for Tanzanite One and Beryl options

The Acute Formulary list for **Tanzanite One and Beryl** is a list of medicines and associated rules that will be applied to acute medicine claims on these options. It is important to ensure that your prescribing doctor refers to the acute formulary applicable to your option when prescribing acute medicine.

The Acute Out-of-Formulary list for Ruby, Emerald, Emerald Value and Onyx options

The Acute Out-of-Formulary list is applied to acute medicine claims on the Ruby, Emerald, Emerald Value and Onyx options. Medicines listed on this formulary will always attract a 30% co-payment. If the medicine is not listed here, it will not attract a formulary co-payment; however, this is subject to the available benefits, Medicine Exclusion List (MEL) and the use of generic and cost-effective therapeutic equivalent medicines.

Formularies, exclusions, and medicine price lists can be found at www.gems.gov.za under Individuals > Formulary Lists > Select formulary files for the relevant benefit year.

Please keep in mind that GEMS will not pay claims for services rendered by a healthcare provider who is not registered under the applicable law. Examples include doctors who are not registered to practise medicine in South Africa and doctors who have restrictions imposed by GEMS. Before using a provider's services, consult with your doctor to ensure that your claims meet the necessary requirements before submitting them to the Scheme.

Use medicine within the Drug Reference Price (DRP)

Effective from 1 October 2024, GEMS uses a medicine reference pricing tool called the Drug Reference Price (DRP) to set the maximum price that the Scheme will pay for certain groups of generically or therapeutically similar medicines. Drug Reference Price (DRP) List, a combination of the Medicine Price List (MPL) and Therapeutic Reference Pricing (TRP). DRP is designed to enhance our service and offer greater benefits to our members.

The maximum price that GEMS will pay for medicine is also indicated on the DRP list. The DRP list can be found on the GEMS website at www.gems.gov.za.

Where a beneficiary or service provider chooses medicine that costs more than the reference price indicated on the DRP, the beneficiary will pay the difference. The DRP does not restrict the beneficiary's choice of medicine - it just limits the price that GEMS will pay for the medicine. Ask your pharmacist to supply medicines generic medicine or advise on a more cost-effective therapeutic equivalent within the DRP where possible, so that you avoid making DRP co-payments.

Generic medicines are safe, registered medicines that contain the same active ingredients as the original or branded medicine and achieve the same therapeutic results at a lower cost.

Get pre-authorisation

If you plan to visit or be admitted to a hospital (out-patient or in-patient) or to go for a scan, get pre-authorisation at least 48 hours before you go to the hospital, or you will incur a co-payment. For example, if you do not get pre-authorisation for your maternity admission, you will pay a R1 000 co-payment.

Pre-authorisation is also required for:

- The 16th and subsequent consultation with a FP or nurse for all beneficiaries on the Tanzanite one and Beryl options.
- Certain out-of-hospital procedures, for example, where a member obtains dialysis on an out-patient basis or for some procedures done at a doctor's rooms.
- In-hospital physiotherapy.
- Wound care.
- Specialised radiology investigations (e.g. CT, MRI, Angiogram, Radio-isotope scans).

Use registered doctors

GEMS will not pay claims for services rendered by a healthcare provider who is not registered under the applicable law. For example, doctors who are not registered to practice medicine in South Africa and doctors who are subject to GEMS restrictions. Speak with your doctor to ensure that your claims meet the necessary requirements before submitting them to the Scheme or using the provider's services.

WHAT TO DO BEFORE GOING TO HOSPITAL

You need to get a pre-authorisation number (PAR) from GEMS no later than 48 hours before you:

- are admitted to a private hospital;
- make an out-patient visit to a hospital (excluding emergencies and public hospitals); or
- have a CT scan, MRI scan or Radio-Isotope study.

You can request authorisation by calling 0860 00 4367. Alternatively, your healthcare provider can create an authorisation online or request one by calling 0860 436 777 or sending an email to Hospitalauths@gems.gov.za together with all the required information.

What happens in an emergency if I cannot get pre-authorisation for the treatment?

If you need emergency treatment or are admitted to the hospital on a weekend, public holiday, or at night, you or a family member must contact GEMS on the first working day following the incident. Failure to request authorisation will result in a R1 000 co-payment, which the member must pay out of pocket, according to the Scheme Rules.

Obtaining pre-authorisation does not guarantee payment, nor does it imply that the service will be fully covered by the Scheme. The Scheme Rules will govern the payment of all benefits. For example, if the benefit is covered at 100% of the Scheme Rate but the doctor charges 200% of the Scheme Rate, you must pay the difference.

Discuss costs with the doctor

Speak with your doctor to find out if they will be charging Scheme Rates and if any non-covered items will be used during your stay, procedure, or treatment. This will enable you to be aware of all payments that you may need to make out of your own pocket.

Note: It is your responsibility as a member/ beneficiary to check whether there will be charges above Scheme Rates, or procedures that are excluded or not covered. More information on this is included in the 'What GEMS does not pay for' section on page 24.

What happens if I do not get pre-authorisation?

If you fail to get pre-authorisation for a planned event or authorisation on the first working day after an emergency event, public holiday, or weekend, you will be liable for a co-payment of R1 000.

How to avoid fraud, waste and abuse when admitted to a hospital

Being over-serviced means that a provider conducts tests that are not necessary or medically required for your condition. This is an example of waste.

A fraudulent claim means that a provider bills you for services not rendered. Always check your claims and codes billed. If you suspect that there has been either over-servicing or fraudulent billing, please contact the anonymous 24-hour toll-free GEMS Fraud, Waste and Abuse Hotline: 0800 21 2202.

The most common examples of fraud by a service provider include:

- Charging the (higher) initial consultation tariff for both initial and follow-up visits, which is incorrect as the cost of an initial consultation and a follow-up consultation is not the same.
- Using code 0011 for 'emergency for after-hours consultations', even when it is not an emergency, and/or the doctor was in theatre for the day.

It is important to be mindful of the following to minimise fraud, waste, and abuse:

1. Always check with the treating doctor or specialist if they charge the Scheme rate. The difference between the billed rate and the Scheme rate could be exceedingly high and will become your responsibility. Negotiate with your service provider for the best rates.
2. Do not share your medical aid card or details with anyone. It is fraudulent to have a third party receive treatment using your medical aid card.
3. Make sure you have an authorisation number at least 48 hours before admission. In an emergency, an authorisation can be obtained the next working day.
4. Always use hospitals and service providers on the GEMS Network to avoid co-payments.
5. Ensure that you have enough benefits to cover the cost of the treatment.
6. Confirm any exclusions that the Scheme would not cover with your service providers.
7. Ensure that you get a copy of the authorisation, codes, and approved length of stay for your hospital admission.

8. To avoid an extended length of stay in the hospital, ask your doctor if you can take antibiotics at home.
9. Before you are discharged, check with the hospital to see if all codes, length of stay, and levels of care have been updated.
10. Check that the claim reflects the treatment that you have received and report it if you have been charged for treatment not received.
11. Be aware of your treatment and don't be afraid to speak to your doctor if you are not sure.

Tip: Avoid being charged for an extra day's stay by asking your doctor about the discharge option. If your doctor discharges you in the morning, ensure that you are discharged from the hospital by midday (12H00). Staying longer without being discharged by the hospital, for example, while waiting for transport, will result in an additional half day's stay charged on the hospital account, which will not be covered by the Scheme.

CLAIMS SIMPLIFIED

Who can claim?

The registered member or his/her dependant(s) can claim. A healthcare service provider can submit a claim on behalf of the registered member or dependant provided that the claim is valid, and the member or dependant is an active member of the Scheme.

What information is required when a member claims?

- Your membership number.
- The medical scheme's name (GEMS in this case).
- Your benefit option (Tanzanite One, Beryl, Emerald Value, Emerald, Onyx, or Ruby).
- Your surname and initials.
- The patient's date of birth and dependant code as it appears on your membership card.
- The name of the healthcare service provider.
- The valid practice code of the healthcare service provider.
- The date of the service rendered.
- The type and cost of treatment.
- The pre-authorisation number (if applicable).

- The tariff code (this is from the treating healthcare service provider).
- The relevant ICD-10 code/s.
- The name of the medicine, dose, quantity and NAPPI code for a medicine claim.
- If you paid for the healthcare service or treatment, please attach the proof of payment, and highlight it clearly. The proof of payment can either be a valid receipt from the healthcare service provider, an Electronic Fund Transfer (EFT) or a bank deposit receipt.

How is the claim processed?

When the Scheme receives a Claim, the Claims department assesses it according to the Scheme Rules. If the claim meets the Scheme's funding guidelines, GEMS will pay the claim from the available benefits, subject to the membership being active and valid at the time the service was rendered.

Sometimes, additional information is required from you or your healthcare provider, e.g., the ICD-10 code, clinical motivation, a clear copy of the account, a detailed account, proof of payment, etc. when assessing the claims. If this information is not available, some claims may not be paid.

When does GEMS pay claims

GEMS has two payment runs per month (one mid-month and another one at the end of the month). Your claim will be settled on either one of these runs, but that depends on the date when the Scheme receives your claim and the necessary supporting documentation.

Visit the website to view our claims run dates for 2025.

Are claims for over-the-counter medicine processed immediately?

Your pharmacy can send medicine claims to us electronically at the point of sale. GEMS will apply our Scheme Rules so that you know if GEMS will pay for the medicine. You will get your medicine immediately if you have available funds or benefits. If your medicine is not on the Scheme list, a a co-payment may be required from you, or regrettably, your claim may be rejected. This information will be shared with you by the pharmacist, and you will likely receive an SMS from GEMS if your contact details are up to date on our database.

Claims refunds

You can claim a refund from the Scheme when you pay a healthcare service provider in advance for a service that the Scheme would ordinarily cover. Your benefit option and available benefits, the applicable Scheme Rules, and the rates billed by the service provider will determine whether we will issue a refund.

We pay refunds to members electronically into the banking details we have on record. Therefore, please refer to your claims statement to verify that we have the correct banking details.

Claims alert SMS

You can sign-up to get a claims alert SMS every time GEMS processes your claims. These SMSs acknowledge that we've received your claim(s), but it doesn't serve as a guarantee of payment. Please call 0800 004 367 (toll-free) if you'd like to get a claims alert and ensure that we have your current cell phone number.

Please note: If you get a claim alert SMS for a claim that you do not recognise, report it to the Scheme by calling us on 0860 00 4367 and we'll investigate the matter.

How to read your claims statement

You will get a claims statement after a claims payment run in which the claim was settled. Please read your claims statement carefully to understand how your claim was processed. If we did not pay your claim, the claims statement will state the reason why we did not pay it using a rejection code. The rejection code is described in full at the end of the claims statement with the next steps to be followed.

If the reason requires an action, please resubmit the claim with the applicable information.

Please note: Claims submitted incorrectly will not be paid by the Scheme. We will send you a claims statement explaining the reason why your claim was not paid. We will return your claim to you, or your healthcare service provider and you will need to give us the correct information and resubmit the claim within 60 days from when it was returned for correction. You can also call us on 0800 004 367 (toll-free) if you would like to know why your claim was rejected.

submit your claim correctly the first time!

Direct payments to healthcare providers

Please note that medical schemes are obliged to implement a proper system of financial control, which would include systems that prevent payments from being made to providers where it is reasonably certain that such providers are engaged in fraud, theft, professional misconduct, or negligent behaviour which is causing the Scheme financial loss. This principle is recognised by the provisions of the Medical Schemes Act.

In the event of a review pertaining to alleged fraudulent or irregular activity taking place, the Scheme may suspend payment of the claim, unless doing so would not be in the best interest of the Scheme. Where the Scheme becomes aware of possible irregular claims, it has an obligation to act in terms of its policies and prevent further loss, which it may do by terminating direct payment to the provider concerned.

The Scheme will not accept claims submitted by the healthcare provider and the member will be responsible for submitting their own claims to us for a refund. Members, in this instance, will have to pay the medical costs for the services rendered by the relevant healthcare provider and can claim the money back from GEMS.

Please remember that when you submit your claims, your submission must include a complete invoice for the service rendered and a valid proof of payment, in the form of:

- A receipt with the healthcare service provider's details.
- An Electronic Funds Transfer (EFT) receipt; or
- A bank deposit receipt.

Remember: If you receive a claim alert SMS for a claim you are not aware of, please report it to GEMS as soon as possible by calling us on 0800 004 367 (toll-free). Claims submitted to GEMS should only be for services actually rendered to GEMS members.

International Claims

GEMS does not cover medical expenses incurred outside South Africa. For that kind of claim, a member must take out travel insurance for medical cover abroad.

When a member is stationed abroad by their employer, international claims are covered, subject to GEMS funding rules and tariff rates. The exchange rate difference, the type of service billed, or the type of medicine billed may differ from the South African benefits and, therefore, would result in a shortfall. Should you have any enquiries on how international claims work and if you are eligible to claim, please contact GEMS on 0800 004 367 (toll-free) where your personal profile can be assessed.

Why claims are rejected, not paid or short-paid?

1. Incorrect/invalid member or dependant information

It is important that your information is updated so that we can process your claims promptly. We rely on your correct information to ensure that we process your claims.

When you make a claim on behalf of your dependant(s), please ensure that they're registered with the Scheme and that their details are captured on the claim.

2. No pre-authorisation number for oncology treatments and hospitalisation-related

Although your treatment is authorised, your doctor needs to inform GEMS about any changes in your treatment so that we can evaluate your treatment plan and update the authorisation accordingly. If your doctor doesn't inform us about the changes, we may reject your claim (as per the Scheme Rules).

- Pre-authorisations on medicine claims that are not approved for chronic benefits.

Use in-formulary medicine

3. To get authorisation on medicine claims you must have a copy of the following:

- A valid prescription detailing the doctor's details (name and practice number).
- Diagnosis or ICD-10 codes.
- Medicine details (strength and directions for use).

Note: You, your doctor, or your pharmacist can register your condition immediately by calling the Chronic authorisation department on 0800 004 367 (toll-free).

4. No available benefits

When you've reached your benefit limits, GEMS cannot make any more claim payments on your behalf, unless the claim qualifies to be funded as PMB.

5. Member or dependant missing a doctor's appointment.

GEMS will not be held liable for the costs if you (or your dependants) miss a doctor's appointment. Any costs billed in such an event by your healthcare service provider will be for your own account.

6. GEMS will not pay for claims for services rendered by a healthcare service provider who is not registered in terms of the relevant law

- If a doctor is not registered to practice medicine in South Africa, GEMS will not cover that claim.
- You will need to ask the healthcare service provider to confirm that they have a valid practice number to add on the claim.

Claims must be submitted to the Scheme before the last day of the fourth month after the medical service was rendered. For example: if the service is rendered on the 15th of February 2025, the claim must be submitted to us by the 30th of June 2025. GEMS will not pay any claims received after this 4-month (120 days) period in accordance with the Regulations of the Medical Schemes Act. You will be liable to pay for the claims that you have not submitted to us within the 4-months. Consult your healthcare service provider to find out if they will submit your claim to the Scheme or if you should submit your claim.

7. Treatment claims received after a member has resigned from working in the public service or from GEMS

GEMS is a restricted medical scheme designed for public service employees or participating employers approved by the Board of Trustees. Anyone who is not a public service employee, retired employee or a GEMS participating employer cannot become a member of the Scheme. If you resign from your public service job, your GEMS membership is terminated immediately. If you or your healthcare service provider claims for services rendered after you resigned from the public service or from GEMS, you will be held liable for the relevant medical costs. The use of the Scheme medical aid after your resignation from the public service is fraudulent.

8. Scheme exclusions

There are specific conditions and treatments that the Scheme cannot pay for, in line with the Medical Schemes Act.These items or procedures that are not covered by the Scheme are called "exclusions". You must ensure that the procedures, treatments, or medication you receive are covered as GEMS will not pay for excluded medical services or items. Refer to Rule 16 and Annexure E of the Scheme Rules for the list of exclusions.

9. Incorrect/invalid ICD-10 codes on the claim

Request the healthcare service provider to ensure that the ICD-10 code on your claim is correct. This is the diagnostic code that assists the Scheme with information about your diagnosis and the related service that was rendered.

10. Duplicate claim

The Scheme will reject a claim if the same claim was already submitted by a member or service provider and paid by the Scheme.

11. Collect your chronic medicine within 28 days

Every 28 days, GEMS allows you to pick up your chronic medicine prescription from the pharmacy. If you go to the pharmacy too soon to fill your prescription, your claim will be denied because it is too early to collect your chronic medicine.

You can manage this by noting your collection date and making sure it is 28 days after your last claim. You can also inquire with your pharmacist about the next collection date. This will help you ensure that your medicine is collected on time, saving you time and money on travel.

Note: For international travel exceptions, please contact us to arrange for an advance supply one month before travelling outside South Africa.

Remember: Incorrectly submitted claims will not be paid. You will be sent a claims statement explaining why your claim was not paid. Your claim will be returned for correction, and you or your healthcare provider must provide the correct information and resubmit the claim within 60 days of the date the claim was returned.

Contact GEMS on 0800 004 367 (toll-free) if you are not sure why your claim was rejected. Visit www.gems.gov.za to access the Claims Guide.

12. Why are some claims from healthcare service providers rejected or partially paid?

Full rejections may be due to the following reasons:

- Services not covered.
- Benefits being exhausted.
- Your benefit option does not cover that service.
- A service provider who may be undergoing an investigation.
- Membership issues such as a suspension, termination or not being a GEMS member.
- There may be outstanding clinical information that is required to approve your authorisation.

Partial payments may be due to the following reasons:

- Depleted benefits.
- Use of non-network, non-contracted or non-nominated provider
- Specialist consultations without obtaining a referral where required
- Using medicine that is not included in the formulary or branded medicine where a generic is available

We encourage you to familiarise yourself with your medical aid benefits and the requirements for submitting claims by visiting the GEMS website at www.gems.gov.za

THE GEMS NETWORK OF HEALTHCARE PROVIDERS

GEMS has a network of healthcare providers that includes Family Practitioners (FPs), Specialists, Pharmacies, Dental Health Practitioners, Optometrists, Emergency Medical Services, Hospitals, Renal Dialysis Providers, and Chronic Back and Neck Rehabilitation providers. These GEMS network healthcare providers have committed to providing you with excellent quality healthcare at Scheme rates with no co-payments or additional costs.

Family Practitioner (FP) nomination

Your Family Practitioner (FP) is critical to providing you with high-quality care. Consulting the same FP allows them to gain a thorough understanding of your health and treatment history, allowing them to make informed healthcare decisions, such as determining whether you need to be referred to a specialist. As a result, you will receive the best possible care from the right person who has the necessary skills and knowledge about your condition and medical history. This also means you will have more say over how your benefits are managed. Due to these advantages, GEMS encourages you and your dependants to nominate a GEMS network FP (see next section).

Tanzanite One members have unlimited consultations with a nominated FP, as well as 3 consultations with a non-nominated network provider per year for medically appropriate consultations. A 30% co-payment will apply once these have been depleted. Pre-authorisation is required after a member's 15th FP and Nurse visit.

Beryl members have unlimited consultations with network FPs. Consultations with a non-network FP are limited to 3 visits per family per year, subject to limits for medically appropriate consultations. A 30% co-payment will apply once these have been depleted. Pre-authorisation is required after a member's 15th FP and Nurse visit.

How members on the various options are affected by FP nominations

Emerald Value members need to consult with a nominated FP, and the benefit is subject to the block benefit. A 30% co-payment will apply to claims for consultations with non-nominated network FPs, subject to benefits and limits.

Ruby, Emerald, and Onyx members will not incur penalties for not having a nominated FP.

FP nomination for Emerald Value and Tanzanite One

- Emerald Value and Tanzanite One members must nominate an FP to coordinate their care.
- If you are on one of these options, you can nominate up to two different FPs for each of your dependants, should you need to.
- Failure to nominate an FP will result in any application to join these options being placed on hold, in accordance with the Scheme Rules.
- Once your nominated network FP is selected, you will receive communication to confirm the selection. GEMS encourages you to present this confirmation to your FP at the time of the consultation.

It is compulsory for members on the Tanzanite One and Emerald Value Option to nominate a FP to coordinate their care

What happens if my nominated FP is not available?

- Members on the Ruby, Emerald and Onyx options can consult with any other Ruby, Emerald and Onyx network FP. Non Network FP consultations will be reimbursed at Scheme rates and may result in a co-payment if the provider charges more than the Scheme rates.
- Members on the Emerald Value and Tanzanite One option may obtain authorisation for 3 voluntary out-of-hospital consultations with a non-nominated network FP per family per year with no co-payment, subject to available benefits and limits. Once the three visits have been depleted, a 30% co-payment will apply to claims for any additional consultations with a non-nominated network FP, subject to available benefits and limits.

- You can update your nominated FP every 6 months.
- You are allowed to nominate two FPs per beneficiary.

Coordination of Specialist Care

Specialist referral is in place for the Tanzanite One, Beryl and Emerald Value options.

- Members on the Tanzanite One and Emerald Value option need a referral letter before consulting with a specialist. Referrals from a non-nominated FP will also require a specialist referral authorisation number. In the event of the visit not being approved, the member will incur a 30% co-payment.
- The Beryl network FP must obtain a referral number for their Beryl patient before making an appointment to see a specialist. This can be done by calling the GEMS Provider Call Centre on 0860 436 777.

We encourage members to consult their network FP before making an appointment to consult a specialist. This will ensure that the patient is referred to the appropriate specialist.

Types of specialist practices that require a referral from a nominated FP:

- Cardiologist
- Paediatric Cardiologist
- Dermatologist
- Gastroenterologist
- Gynaecologist (excluding maternity cases)
- Neurologist
- Neurosurgeon
- Orthopaedic surgeon
- Otorhinolaryngologist (ENT)

- Paediatricians (excluding children under 2 years of age)
- Physician
- Plastic and reconstructive surgeons
- Psychiatrist (excluding renewal of prescription)
- Pulmonologist
- Rheumatologist
- Surgeon
- Urologist

The GEMS Specialist Network comprises Obstetricians and Gynaecologists, Paediatricians, Psychiatrists, Anaesthetists, as well as Surgeons and Physicians, including sub-disciplines such as Neurologists, Cardiologists, Ophthalmologists, Urologists, Neurosurgeons, ENT surgeons, Cardiac and Thoracic surgeons, and Orthopaedic surgeons. Network specialists have agreed to charge a contracted rate so that you will not incur unnecessary co-payments (although you need to keep in mind that claims will be paid subject to your available benefits).

Members on the Tanzanite One and Emerald Value Option need to keep the following in mind:

- You will not require an authorisation if the specialist referral is requested by your nominated FP.
- Make sure that your FP, Specialist, Pharmacy, Optometrist and Dental Health Practitioners are on the GEMS network before you visit them. This will ensure that you do not have to pay out of your pocket for the consultation or treatment.
- All medicine is subject to formularies, regardless of the prescribing doctor's discipline (type of doctor).

- Ask your FP whether they can dispense medicine. If they can do so, you do not need to obtain your acute medicine from a pharmacy (in which case you may have had to make a co-payment or even pay the entire claim yourself).
- All medicines are subject to the Comprehensive Acute and Chronic Formulary lists which are accessible on the GEMS website at www.gems.gov.za.

Important information:

- Pathology and radiology tests must be in line with the GEMS formulary (list of approved tests or services) for Tanzanite One and Beryl options.

GEMS MEDICINE BENEFIT

Medicine: Know the difference

Acute medicine
Acute medicines are prescribed for the treatment of a short-lived disease or disorder.

- Members on the Tanzanite One and Beryl options can obtain acute medicine from a GEMS dispensing doctor (a doctor who is licensed to supply medicine from their practice rooms) or from a GEMS Network Pharmacy, subject to the GEMS Tanzanite One and Beryl acute formulary.
- Medicines not listed on the formulary will not be covered. Please note: The GEMS Tanzanite One and Beryl acute formulary are product-specific, and each listed product has an indicator or formulary status (in formulary/out-of- formulary).

- Products listed on the acute out-of-formulary list will attract a 30% co-payment if claimed on the acute medicine benefit for the Ruby, Emerald, Emerald Value and Onyx options.

The acute formulary applicable to the Tanzanite One and Beryl options, as well as the acute out-of-formulary list applicable to the Ruby, Emerald, Emerald Value and Onyx options, can be found on the GEMS website at www.gems.gov.za (For Individuals > Formulary Lists > Select the formulary file for the relevant benefit

Self-medicine

Also known as over-the-counter medicine, self-medicine does not require a prescription from your doctor. Examples of these would be medicine for ailments such as a headache, cold, or an upset stomach.

- For members on the Ruby, Emerald, Emerald Value and Onyx options, these medicines may be obtained from any pharmacy.
- Members on the Tanzanite One and Beryl options can make use of a GEMS network dispensing doctor or a GEMS network pharmacy. Your pharmacist will be able to tell you if your medicine will be covered by the Scheme.

The chronic, acute, and self-medicine benefits above are subject to Formularies, the use of Designated Service Providers (DSPs), generic alternatives or cost-effective therapeutic equivalent (DRP), and option-specific Scheme Rules such as benefit limits. It is, therefore, also important to consult your option-specific Scheme Rules for more information on where these apply to your option. Visit the GEMS website at www.gems.gov.za.

The Chronic Medicine Programme

Chronic medicine is used on an ongoing basis to treat long-lasting (chronic) illnesses that can compromise your quality of life, be disabling and/or potentially life-threatening, such as diabetes or high blood pressure. These illnesses have a negative effect on you and your quality of life. Chronic medicines need to be taken regularly, over an extended period, to manage the symptoms or control the effects of the chronic illness.

To obtain authorisation for new chronic conditions, you, your doctor, or your pharmacist can call 0860 004 367 or email chronicauths@gems.gov.za. Only if your condition has been pre-approved will medicine be paid from the chronic medicine benefit. The Chronic Disease List (CDL) shows the conditions covered as PMBs on all GEMS options according to legislation and subject to managed care protocols, and formularies.

When calling to authorise a new chronic condition, have a copy of the prescription available, detailing the doctor's details (name and practice number), the diagnosis or ICD-10 codes, and the medicine details, such as the strength of the medicine and directions for use.

When your doctor has issued a new prescription, email a copy of the new prescription to chronicdsp@gems.gov.za to ensure non-interruption of your chronic medicine.

GEMS will remind you to visit your doctor for a new prescription before the current one expires. This is also an opportunity for your doctor to review the outcome of your current treatment and perform relevant tests to monitor your chronic condition, if necessary. You will have access to a care plan, which is a list of out-of-hospital services relevant to the chronic condition once you have been registered for a chronic condition on the PMB Chronic Disease List (CDL). The care plan includes a variety of services available such as doctor's visits, blood tests (pathology), and x-rays (radiology), to ensure that you receive enough benefits to proactively manage and monitor your condition. There are no care plans for non-PMB chronic conditions.

Chronic Disease List (CDL) for all options. All options cover the following list of chronic conditions:

Addison's Disease; Asthma; Bipolar Mood Disorder; Bronchiectasis; Cardiac Failure; Cardiomyopathy; Chronic Renal Disease; Coronary Artery Disease; COPD; Crohn's Disease; Diabetes Insipidus; Diabetes Mellitus Type 1; Diabetes Mellitus Type 2; Dysrhythmias; Epilepsy; Glaucoma; Haemophilia; HIV; Hyperlipidaemia; Hypertension; Hypothyroidism; Multiple Sclerosis; Parkinson's Disease; Schizophrenia; Ulcerative Colitis; Rheumatoid Arthritis; Systemic Lupus Erythematosus.

ADDITIONAL CHRONIC DISEASE LIST

In-Hospital	Tanzanite One	Beryl	Ruby	Emerald Value	Emerald	Onyx
Acne				✔	✔	✔
Allergic rhinitis				✔	✔	✔
Alzheimer's disease				✔	✔	✔
Ankylosing spondylitis				✔	✔	✔
Anorexia nervosa				✔	✔	✔
Anxiety	✔	✔	✔	✔	✔	✔
Attention deficit and hyperactivity disorder	✔	✔	✔	✔	✔	✔

In-Hospital	Tanzanite One	Beryl	Ruby	Emerald Value	Emerald	Onyx
Barrett's oesophagus						
Benign prostatic hyperplasia			✔	✔	✔	✔
Bulimia nervosa				✔	✔	✔
Delusional disorder				✔	✔	✔
Dementias, including (but not limited to), multi-infarct, sub-cortical vascular and alcohol				✔	✔	✔
Depression*	✔	✔	✔	✔	✔	✔
Dermatitis				✔	✔	✔
Eczema				✔	✔	✔
Gastro-oesophageal reflux disease (GORD)				✔	✔	✔
Generalised anxiety disorder				✔	✔	✔
Gout				✔	✔	✔
Huntington's disease				✔	✔	✔
Hypoparathyroidism**				✔	✔	✔
Hyperthyroidism***				✔	✔	✔
Interstitial lung disease				✔	✔	✔
Meniere's disease			✔	✔	✔	✔
Menopause**				✔	✔	✔
Myasthenia gravis				✔	✔	✔
Narcolepsy				✔	✔	✔
Neuropathies				✔	✔	✔
Obsessive compulsive disorder				✔	✔	✔
Osteoarthritis			✔	✔	✔	✔
Osteopenia				✔	✔	✔
Osteoporosis				✔	✔	✔

In-Hospital	Tanzanite One	Beryl	Ruby	Emerald Value	Emerald	Onyx
Paget's disease				✔	✔	✔
Post-Traumatic Stress Syndrome				✔	✔	✔
Psoriasis			✔	✔	✔	✔
Stroke***				✔	✔	✔
Systemic Sclerosis				✔	✔	✔
Thrombocytopenic Purpura****				✔	✔	✔
Thrombo-Embolic Disease***			✔	✔	✔	✔
Tourette's Syndrome				✔	✔	✔
Valvular Heart Disease***				✔	✔	✔
Zollinger-Ellison Syndrome				✔	✔	✔

HOW TO OBTAIN CHRONIC MEDICINES WITH DISEASE AUTHORISATIONS

Your doctor has prescribed chronic medicine for you to manage your chronic condition. What comes next?

Have you registered for chronic medicine for this condition before?

NO

To access your Chronic Medicine Benefits, you must register the new condition. To register, you, your doctor or your pharmacist can contact us telephonically on 0860 00 4367 and email your script to chronicdsp@gems.gov.za. Your FP can call us on 0860 436 777 and email your script to chronicdsp@gems.gov.za.

YES

Go straight to your pharmacy with your new script. To avoid a DSP co-payment, you must be allocated to a pharmacy registered on the GEMS Network. You will have access to a list of pre-approved medicines for that condition, called a basket. If your doctor prescribes a new medicine for the condition within the basket, you will already be approved for it.

When you go to the pharmacy, they will process your claim and provide you with feedback from the system.

You can choose to pay for the medicine from your own pocket.

OR

You can discuss the reasons for the decline with your doctor. If possible, they may change to an alternative medicine within the basket.

OR

You may obtain a letter of motivation from your doctor and/or additional test results if required to support the choice of medicine by your doctor.

What if my medicine is declined?

If your medicine is declined, it means your medicine is not part of the defined basket of medicines for that condition or your chronic medicine benefit (if not PMB) has been exceeded for the year.

If your doctor changes the medicine on your prescription, start at the pharmacy again.

The Chronic Medicine Management department must pre authorise your chronic diagnosis for the prescribed medicine to be re-imbursed through the Chronic Medicine benefit. Some medicines are not fully reimbursed if they are not on the GEMS formulary or if they fall outside of the Scheme's reimbursement rate, which is known as the Drug Reference Price (DRP). When a medicine does not meet the reimbursement guidelines for a specific condition, it may be denied. Always consult your doctor to ensure that the most cost-effective medicine is prescribed in accordance with DRP and the GEMS formulary so that you do not have to pay out-of-pocket. We will review your pre-authorisation application and check it against the Scheme Rules to see if we can cover the medicine under the chronic medicine benefit.

- If we approve your application, you will receive a Medicine Access Chart listing the chronic conditions and/or medicine that the Scheme has agreed to pay for from your chronic medicine basket.
- If the chronic conditions and/or medicine that we have agreed to pay for differ from the medicine your doctor has prescribed, we will attach a letter to your Medicine Access Chart explaining the reasons for this. We will also send a copy of the letter to the doctor who prescribed the medicine.

Please keep in mind that the duration of authorisation varies by medicine. Some medicines may be authorised on an ongoing basis, whereas others may only be authorised for a limited time. The Medicine Access Chart will show how long the medicine has been approved for.

What if my chronic medicine authorisation request has been declined?

If your chronic medicines authorisation request is declined, GEMS will send you a letter with a copy sent to your prescribing doctor explaining the reason for the decline. If additional clinical information is required, your request will be reconsidered once your doctor has provided all relevant information. Your doctor can get assistance by dialling 0860 436 777.

Can I appeal a medicine authorisation?

Yes, you can appeal the decision on your pre-authorisation application. To appeal, you must ask your doctor to write a clinical motivation and email it to chronicauths@gems.gov.za. or your doctor can call us on 0860 436 777. The clinical motivation will be considered carefully by a medical advisor and the outcome of the appeal will be communicated to you and the doctor.

How do I obtain my approved chronic medicine?

You can get your chronic medicine from the GEMS courier pharmacies or a GEMS network pharmacy. Once you have indicated your preference, you can either collect your medicine at your nearest GEMS network pharmacy or the courier pharmacy will contact you to arrange for medicine delivery. If you choose to obtain your approved chronic medicine from a supplier who is not a GEMS courier pharmacy or a GEMS network pharmacy, you will be liable for 30% co-payment to the pharmacy or dispensing doctor.

Can I change my registered chronic medicine pharmacy at any time?

After being contacted by the Pharmacy Network Manager and registering with either the courier pharmacy or a specific GEMS network pharmacy, members are expected to stay with that pharmacy for at least six months before being allowed to change.

However, if a member on the Chronic Medicine Programme changes their home or work address, they may contact the Pharmacy Network Manager to update their registered pharmacy. The Pharmacy Network Manager contacts patients enrolled in the Chronic Medicine Programme twice a year to confirm or reconsider whether they want their medicine delivered by a courier pharmacy or collected at the GEMS network pharmacy.

Can I use any GEMS network pharmacy for my chronic medicine, or am I required to use only my registered GEMS network pharmacy?

- Once you have been allocated to your nominated pharmacy, you must obtain your medicine from only that pharmacy for a minimum period of six months before you change.
- You will be allowed to obtain your authorised chronic medicine from a non-nominated pharmacy only once during the benefit year, except where a courier pharmacy is the nominated pharmacy. Once this allocation is exceeded, you will be liable for a 30% co-payment.

- **You can however request to be re-allocated if you meet the below criteria:**

- You have changed employer or your employment address.
- You have changed your residential address.
- Six months have passed since the initial allocation.
- Your preferred pharmacy is no longer part of the network.

If you meet the above criteria for pharmacy re-allocation and you wish to change your allocated pharmacy, please contact us to facilitate the change.

How often do I need to supply the GEMS courier pharmacy or GEMS network pharmacy with a repeat prescription?

You must provide a valid doctor's prescription to the courier pharmacy or your GEMS network pharmacy before they can provide you with your chronic medicine. Prescriptions must be renewed every six months, as required by law. Schedule-6 medication prescriptions must be renewed monthly.

A prescription cannot be renewed for a period of more than six months. If we have your cell phone number, GEMS will text you a reminder to get a new prescription before your current one expires. Whether you get your medicine from the courier pharmacy or a GEMS network pharmacy, you must send in a new prescription when it is due. If your prescription has expired, your preferred pharmacy will not send or provide you with medicine.

GEMS MEDICAL DEVICES

GEMS has designed its Medical Device benefit to ensure that all beneficiaries have access to cost-effective, quality medical devices and appliances, prostheses, and associated professional services, irrespective of their benefit option.

The following types of appliances require pre-authorisation from GEMS:

- Blood pressure monitors.
- Braces (knee and back).

- Commodes.
- Hearing devices and repairs.
- Insulin pumps.
- Nebulisers.
- Orthotic shoes.
- Oxygen concentrators.
- Prosthetics.
- Pulse oximeters above R467.
- Sleep apnea devices.
- Specialised beds.
- Suction units.
- Wheelchair accessories and repairs.
- Wigs.

Two medical appliance categories

When prescribing a medical device or appliance, your healthcare professional may select from a wide range of GEMS-covered devices and appliances. These medical devices and appliances are divided into two categories: those that do not require pre-authorisation and those that require pre-authorisation from GEMS.

Certain devices and appliances are specifically excluded in the Scheme Rules and thus are not covered by GEMS. It is important to care for your devices and appliances, as costly medical appliances, such as wheelchairs, hearing aids, CPAP machines, etc., are expected to last for a reasonably long time. For this reason, their benefits are made available over longer cycles than a single benefit year. Please refer to the table below for benefit limits.

Pre-approved list of medical devices with no pre-authorisation required:

When prescribing an appliance for GEMS patients, service providers can choose from a wide variety of medical devices without any need for pre-authorisation. GEMS reserves the right to change the approved list based on trends and escalated costs. The medical device list can be viewed by clicking here.

Medical devices that require pre-authorisation

If the required device is not on the pre-approved list, it will have to be pre-authorised. Certain professional fees for customised products will also require pre-authorisation and be subject to managed care protocols.

This is because GEMS intends to assist members in avoiding unforeseen co-payments, specifically where benefit sub-limits apply.

How to obtain pre-authorisation for medical devices

Providers should request authorisation by sending an email to enquiries@gems.gov.za and include the following documentation:

- A prescription or letter with clinical information.
- A quotation
  - From a registered provider (a provider with a practice number) that includes a description of the device or appliance, the NAPPI code, the quantity requested, and the price.
  - From an appropriately registered supplier/manufacturer.
  - Registered with the regulatory body (SAPHRA.)

Please make the provider aware

NB: Some appliance benefits, such as shoe orthotics, wheelchairs, crutches, etc., have a sub-limit, and the claims received for these will be paid accordingly.

It is your responsibility as the member to ensure that all claims submitted on your behalf are valid, as the misuse of membership details to submit fraudulent claims or refund requests may result in the termination of your GEMS membership, criminal prosecution, and/or disciplinary action by your employer.

Some of the costs of these appliances and devices may be above your benefit limit. Always ask your healthcare provider upfront to prescribe appliances that will not require you to pay from your pocket.

When your healthcare provider prescribes appliances or medical devices, make sure you ask your healthcare provider to use the correct NAPPI code and appliances that are on the appliances list; otherwise, your claim may be rejected. Access to the Appliance list is discussed below.

Benefits available for medical and surgical appliances and prostheses in 2025

Option	Prosthesis Benefit Limit	Appliances Benefit Limit
Tanzanite One	R33 831	R7 962
Beryl	R39 825	R13 274
Ruby	R51 010	R19 903
Emerald Value	R51 010	R19 903
Emerald	R51 010	R19 903
Onyx	R68 906	R23 036

Benefits for certain medical devices are made available over longer cycles than a single benefit year, and the table below provides additional details as per the Scheme Rules:

Appliance Category	Quantity Limit	Frequency/ cycle	Eligibility
CPAP	One (1)	36 months	Per beneficiary
Hearing Aid	One (1) Unilateral/ One (1) pair of Bilateral	36 months	Per beneficiary
Insulin pumps and Continuous Glucose Monitoring Devices (CGM)	One (1)	60 months	Per beneficiary, limited to type one (1) diabetic, aged below 19 years
Knee braces	One (1)	Per annum	Per beneficiary
Wheelchair	One (1)	24 months	Per beneficiary
Back braces	One (1)	Per annum	Per beneficiary
Oximeters	One (1)	Per annum	Per family
Compression Stockings	Three (3) pairs	Per annum	Per beneficiary

You and your healthcare practitioner can access more information about covers for various appliances by using the following path: www.gems.gov.za > Healthcare Providers > Medical Appliance List. You can also learn more about the Scheme Rules that apply to such cover under Information > Scheme Rules on our website.

The availability of Ex gratia funding
Ex gratia funding is a concession exercised at the sole discretion of the Ex-Gratia Committee and not a right to which you are entitled. You or your provider may apply to the Scheme for Ex gratia consideration if your benefits are depleted or insufficient. You may request application forms by calling 0860 436 777 or emailing enquiries@gems.gov.za, or you can collect an application form at any GEMS Walk-in Centre.

Complementary GEMS benefits
In cases where your appliance provider is considering orthoses or prostheses for spinal pathology, please remember that GEMS has established a Chronic Back and Neck Rehabilitation (CBNR) Programme that should be explored as a complementary option to increase your well-being.
Read more about this Programme on page 62.

DISEASE MANAGEMENT PROGRAMMES

GEMS offers its members disease management programmes (DMPs) to help manage various chronic diseases and conditions.

HIV Management Programme

All HIV-positive members have access to the comprehensive and effective HIV Management Programme. If you or one of your dependants is living with HIV, it is critical that you register on the HIV Programme so that GEMS can provide you with the support you need to live a healthy and productive life.

Confidentiality guaranteed

GEMS takes great care to protect the privacy of all HIV-positive members and dependants who enrol in the GEMS HIV Management Programme. The programme is managed by a team of healthcare professionals separate from the rest of the Scheme's Programmes. No confidential information is shared with your employer, dependants, or family members.

The HIV Management Programme uses confidential contact channels:

- Telephone: 0860 436 736 (Monday to Friday between 8:00 and 17:00 and Saturday from 8:00 to 12:00).
- Send a 'please call me' to 083 843 6764.
- Email: hiv@gems.gov.za.
- Fax: 0800 436 732.

What HIV benefits are available?

Members on the HIV Disease Management Programme (DMP) have access to the following benefits:

- Medicine to treat HIV/AIDS (antiretroviral therapy).
- Medicine to treat and prevent opportunistic infections related to HIV/AIDS, including multivitamins where appropriate. Please note that a doctor's prescription and pre-authorisation is required for all medicines, including multivitamins.

- All pathology tests required to assess your condition.
- Regular monitoring of your condition to ensure you start treatment at the right time and that it is effective.
- Clinical support and guidelines for your doctors.
- Access to a professionally trained medical team who will review your clinical information and consult with your doctor to ensure that you receive the most appropriate treatment for your condition.
- Reminders for you and your doctor to ensure that all regular check-ups and monitoring tests are done to optimise your treatment where necessary.

- Treatment to prevent the transmission of HIV from mother to child (including treatment for the baby).
- Treatment to prevent the transmission of HIV after accidental exposure to infected bodily fluids (sexual assault, needle stick injury, etc.). Please call 0860 4367 36 if you have had accidental exposure to HIV so that post-exposure prophylaxis (PEP) treatment can be arranged.
- Pre-exposure prophylaxis (PrEP) treatment to prevent the transmission of the virus from an HIV-positive person to an HIV-negative partner.

GEMS has a dedicated, user-friendly HIV Member Guide that contains important information to help you and answer many of your questions. To access go to www.gems.gov.za > For Individuals > Member Guides > HIV Member Guide

How do I register for the HIV DMP?

- Know your HIV status by requesting a doctor or clinic to perform an HIV test. GEMS will pay for one HIV screening test per member per year.
- If you have tested HIV-positive, obtain an application form by calling 0860 4367 36 or use our 'please call me' number 083 843 6764 (available Monday to Friday between 8:00 and 17:00 and on Saturdays from 8:00 to 12:00). Alternatively, send an email to hiv@gems.gov.za or download the form from www.gems.gov.za.
- Visit your treating doctor, who will examine you and complete your application form. You will need to sign the application form and submit it to GEMS.

- The completed form can be emailed in confidence to hiv@gems.gov.za. You can also fax it to the confidential toll-free fax number 0800 436 732.
- We will contact you to discuss the outcome of your application.

- The HIV Management Programme enrols, manages, and supports members living with HIV. The Chronic Medicine Management team, on the other hand, assists members living with all other chronic conditions.
- Members can obtain all chronic medicine (including HIV medicine) from courier pharmacies and GEMS network pharmacies. If you get your antiretroviral (ARVs or HIV) medicine from a pharmacy other than the one you have chosen, you will be liable for a 30% co-payment.

How do I get my HIV medicine?

- When you use a courier pharmacy, your medicine will be delivered to your specified address without anyone knowing what is inside. Beneficiaries who choose to collect their medicine from a GEMS network pharmacy will also be guaranteed confidentiality.
- If you require medicine for another chronic condition (such as high blood pressure), it can be delivered or collected along with your HIV medicine.
- GEMS will send you a reminder to get a new repeat prescription 21 days before your current prescription is due to expire.

Oncology (Cancer) Management Programme

GEMS offers a comprehensive set of oncology benefits that cover diagnosis, treatment, and palliative care. If you or a family member is diagnosed with cancer, it is critical that you enrol in the Oncology Management Programme as soon as possible because all oncology treatments require pre-authorisation and case management.

How to register for the Oncology Management Programme

- Your doctor must email a copy of your treatment plan and histology, which confirms the presence of cancer to oncologyauths@gems.gov.za.
- Once the Oncology Management team has received the treatment plan from your doctor, we will record your details, disease information and proposed treatment.
- Your treatment plan will be reviewed, and if necessary, a member of the clinical team will contact your doctor to discuss more appropriate or cost-effective treatment alternatives.

- After the treatment plan has been assessed and approved, authorisation will be sent to your treating doctor. You will also receive an authorisation letter. The letter will detail the treatment that GEMS has authorised, the approved quantities and how long the authorisation is valid. Oncology medicine may be obtained from any pharmacy that has stock of the medicine required.

Please notify the Oncology Management team if your treatment changes, as your authorisation will need to be re-evaluated and updated. If your doctor fails to notify the Oncology Management team of the change in your treatment, GEMS may reject your claims or pay them from the wrong benefit.

When do you need pre-authorisation?

Even if you are registered on the Oncology Programme, you will need a separate pre-authorisation for any hospitalisation, specialised radiology (for example, MRI scans, CT scans and angiography), stoma requirements or private nursing or hospice services.

Chronic Back and Neck Rehabilitation (CBNR) programme

GEMS provides you with a Back and Neck Rehabilitation Programme to help you or your registered dependants manage your back and neck pain. Positive outcomes include increased flexibility, decreased pain and stiffness, and a more productive lifestyle. The programme consists of carefully planned exercises and advice on how to deal with your back problem while still living a normal life.

The CBNR programme focuses on functional rehabilitation, with controlled exercises, biopsychosocial support, and pain education as key components. Clinical measurements are taken and used to track the progression of your treatment over time. The treatment is delivered by reputable service providers such as Physiotherapists and Biokineticists, utilising protocols and interventions based on international standards.

Members are referred to a facility closest to them to be assessed and obtain a treatment plan formulated to assist their rehabilitation. The treatment can be extended over six weeks, depending on the assessment done at the centre.

How the CBNR programme works:

- Members who are identified or referred to the programme will be contacted by the Scheme to complete a short questionnaire.
- Members will be referred to the nearest centre, and all appointments will be managed by the centre.
- The centre will perform an assessment to determine the treatment required. The treatment must be completed for the member to benefit from the programme.

The CBNR programme intervention entails:

- A comprehensive assessment.
- Based on your risk profile as identified during the assessment, a tailored treatment programme is prescribed. This ranges from one to twelve active treatment sessions.
- At each treatment session, physiotherapy and exercise assist with pain management and muscle relaxation.
- A progress assessment with the healthcare provider must be completed.
- On completion of the programme, a comprehensive outcome assessment is conducted to evaluate progress and measure improvement over the course of the programme.

- Tailored home-based exercises and stretches to ensure that results are maintained in the long term are discussed and shared.
- Follow-up visits to track improvement following completion of the programme may be included.

Which benefits will be used?

The Chronic Back and Neck Rehabilitation Programme benefit will be used for members receiving treatment at the centres. This means that your day-to-day benefits will not be depleted.

How can you access the CBNR programme?

There are several ways to access the programme:

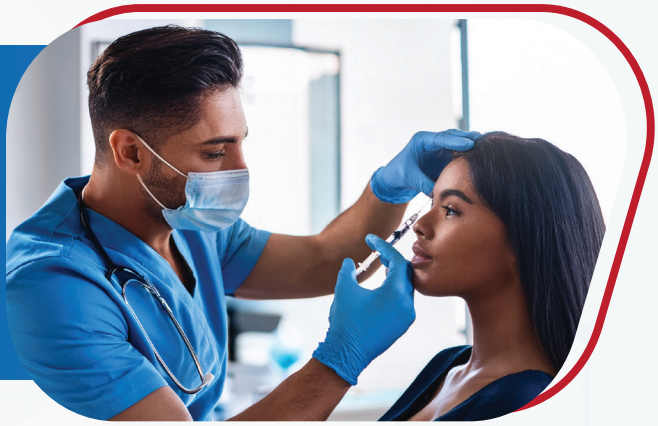
- Telephone: 086 000 4367.
- Email: enquiries@gems.gov.za.
- The Scheme may contact you if you have had back problems in the past and received related treatment.
- Your Family Practitioner (FP) or Specialist may refer you to the programme.

In-Rooms Procedures

GEMS has identified certain procedures that can be performed safely in the doctor's rooms without the need for hospital admission. Speak to your treating provider to enquire, if they can perform the below procedures in their rooms.

The table below lists the procedures that are remunerated at 270% for network specialists and 220% for network Family Practitioners (FPs). 200% for non-network Specialists and Family Practitioners (FPs) of the Scheme rate if performed in the doctor's rooms. The rate is inclusive of equipment and/or instrumentation used for the procedures and it applies to all Scheme options. Please also note that:

- Certain procedures are subject to pre-authorisation.
- The 200% (non-network); 270% for Specialists; and 220% for Family Practitioners (network) tariffs are inclusive of all modifiers (excluding Modifier 0010).
- The list may change as new procedures are added and/or others removed. Any such changes will be communicated.



Procedure Codes	Tariff Description	Pre-authorisation required
	Skin	
0244	Repair of the nail bed (only for ingrown toenail)	No
	Integumentary System	
0307	Excision and repair by direct suture; excision nail fold or other minor procedures of similar magnitude (only for ingrown toe nail)	No
0310	Radical excision of nailbed (only for ingrown toenail)	No
	Nose and Sinuses	
1018	Flexible nasopharynx laryngoscope examination	No
	Stomach	
1587	Upper gastrointestinal endoscopy	Yes
	Gastrointestinal Tract (Intestines)	
1653	Total colonoscopy: (including biopsy)	Yes
1656	Left-sided colonoscopy	Yes
1676	Flexible sigmoidoscopy (including rectum and anus)	No
1677	Sigmoidoscopy: First and subsequent, with or without biopsy	No
1679	Sigmoidoscopy with removal of polyps, first and subsequent	No
1681	Proctoscopy with removal of polyps: First time	No
1683	Proctoscopy with removal of polyps: Subsequent times	No
	Testis and Epididymis	
2207	Vasectomy: Unilateral or bilateral (no extra fee to be charged if done in combination with prostatectomy)	No
	Cataract	
3045	Cataract: Intra-capsular	Yes
3047	Cataract: Extra-capsular (including capsulotomy)	Yes
3050	Repositioning of intra-ocular lens	Yes
3051	Needling or capsulotomy	Yes
3052	Laser capsulotomy	Yes
	General procedures performed in consulting rooms	
2271	Removal of tag or polyp	Yes
2272	Removal of small superficial benign lesions	Yes
2277	Removal of benign vulva tumour or cyst	Yes
2399	Punch biopsy (excluding after-care)	Yes
2442	Insertion of intra uterine contraceptive device (IUCD) (excluding after-care)	Yes
2434	Endometrial biopsy (excluding after-care)	Yes
2565	Implantation hormone pellets (excluding after-care)	Yes
2274	Electro-, cryo-, chemo-, laser therapy of vulva and/or vagina (colposcopy directed)	Yes
2283	Hymenectomy	Yes
2293	Vulva and introitus: Drainage of abscess	Yes
2316	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: First lesion	Yes
2317	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Repeat – Limited	Yes
2318	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Widespread	Yes
2392	Cryo- or electro-cauterisation, or Lletz of cervix (excluding the cost of disposable loop electrode): In consulting room	Yes
2405	Cone biopsy: Cervix (excluding after-care)	Yes
2395	Cryo- or electro-cauterisation, or Lletz of cervix (excluding the cost of disposable loop electrode): Under anaesthetic	Yes
2396	Cautery, laser or Harmonic scalpel treatment of the cervix	Yes
2400	Biopsy during pregnancy (excluding after-care)	Yes
2411	Cervix encirclage: Shirodkar suture	Yes
2413	Cervix encirclage: Lash	Yes

Renal Dialysis Network

GEMS has contracted a Renal Dialysis Network to provide chronic dialysis to all members.

Members who require chronic dialysis must use Renal Dialysis Network providers; otherwise, an out-of-network co-payment of 30% will be charged for each treatment session.

The co-payment will not be applied to:

- Members admitted to hospitals who are receiving acute dialysis. Once discharged, however, chronic dialysis will be covered in full only if received from a Renal Dialysis Network provider.
- Members who were registered on the programme and accessed their treatment at a non-network provider before 1 January 2018.

Patients transferred to the following types of facilities for dialysis:

- Sub-acute facilities (Step-down facility).
- Private rehabilitation facilities.
- State hospitals.

- Out-of-area visits: Beneficiaries who are unable to receive treatment from their regular provider due to travelling must obtain prior authorisation to continue treatment at a Renal Dialysis Network provider at their destination, such as holiday dialysis.

- Cases where there is no Renal Dialysis Network provider within a 30km radius of the GEMS member's place of residence or work, if the necessary services are unavailable at the nearest network facility, the co-payment may also be waived after investigation.

A list of GEMS Renal Dialysis Network providers can be found at www.gems.gov.za

For further information or assistance, please contact the GEMS Call Centre on 0860 00 4367.

In-Hospital Benefit

The Hospital Benefits Management team supports your access to quality healthcare while you are in-hospital and during your transition home.

- The pre-authorisation process facilitates your authorisation of treatment according to evidence-based guidelines to ensure it is appropriate.
- Once you are admitted, the hospital case manager and other service providers will submit information regarding your diagnosis, treatment and stay.

- Accurate information is key to the appropriate application of benefits and facilitation of claims payments.
- The case management team is responsible for updating your hospital authorisation details and communicating with your hospital case managers, treating doctors, you and your next of kin, where necessary, during your admission.

- It is important to update all your contact details and next of kin before being admitted. Refer to third-party enquiries.
- The team will assist you during discharge planning and the transfer of care to your next of kin or caregiver.
- It is important to understand your treatment, and the service providers related to the treatment and to discuss any concerns with your treating doctor.
- To manage the admission, GEMS at times makes use of case managers that are located within the actual hospital. These specialised case managers support the teams and may engage with you during your admission.

ALTERNATIVE TO HOSPITALISATION BENEFIT

GEMS offers access to the 'alternative to hospitalisation' benefit for all members who require medical care and:

- Do not necessarily need to be admitted to the hospital; or
- Require care after an acute hospitalisation event.

This is paid from the overall annual limit, separate from the day-to-day benefit and is subject to clinical approval and authorisation.

What services are covered?

Hospital at Home

What is provided under this service?

- Real-time hospital-grade monitoring at home through the wireless and automatic collection of vital signs data (usually monitored in the hospital). This data is closely monitored by a team of healthcare professionals at their 24-hour medical command centre.
- Intravenous therapy.
- In-person and virtual visits.
- Skilled nursing.
- Access to laboratory services, allied healthcare services e.g., physiotherapy, and short-term oxygen, as required.
- Rapid response protocols. If a patient's condition worsens during treatment, the clinical team will identify such changes and make the necessary arrangements, which may include an increase in visits, early review by the treating doctor, and if required, transfer to hospital.

Which patients are eligible for the Hospital at Home service?

- The patients who would ordinarily require admission to a hospital general ward are eligible, as this service brings hospital-level care to the home.
- Consent is required from both the patient and the treating doctor.
- Benefit management protocols are applied to ensure safety.

- Stoma care.
- The care of long-term ventilated patients.
- Neonatal care.
- This includes prescribed treatments such as intravenous (IV) therapy, Outpatient Antibiotic Treatment (OPAT) and home dialysis.

Services provided by a nurse in the home environment. Examples are:

What is not covered by the "alternative to hospitalisation" benefit?

The benefit does not cover frail care or general assistance with recuperating following any illness. The request must be medically necessary for the benefit to apply.

- Assistance with mobilisation following a long-term illness.
- Wound care.

Home Oxygen

Home oxygen therapy is prescribed when you have a condition that affects your breathing pattern and requires assistance. Certain medical conditions may require members to use oxygen therapy continuously to manage their symptoms and improve quality of life, e.g., Chronic Obstructive Pulmonary Disease (COPD). Home Oxygen therapy involves breathing through a mask or tube connected to a device in your home. Only use home oxygen therapy if your Family Practitioner (FP) or Specialist prescribes it.

GEMS funds home oxygen therapy for clinically appropriate conditions, for both Long-term oxygen therapy and Short-burst oxygen. To find out if home oxygen therapy is covered for you or your dependant, please email our team at hospitalauths@gems.gov.za

Hospice care

This is available for terminally ill members who require end-of-life care, such as pain management. It can be provided in a hospice or at home.

Palliative care programme
For members registered on the oncology programme.

Physical rehabilitation

- This is the care that may be required after an acute traumatic episode (e.g., post-surgery, physical trauma, or amputation) or a medical episode (e.g. after a stroke) to help beneficiaries recover as fully as possible.
- There is a special physiotherapy benefit available for post-hip, knee, or shoulder replacement.

Step-down/Sub-acute care

Step-down/Sub-acute facilities are self-contained and functionally independent facilities that treat patients using established clinical and functional outcome-based protocols in conjunction with a multidisciplinary team. These facilities do not have operating theatres or specialised levels of care. Patients admitted to these facilities should be medically stable and must not require surgery or a high level of technological equipment for monitoring, diagnosis or treatment.

Other medical care

How do members access this benefit?

To access this benefit, the treating healthcare provider must email their clinical view in a referral or letter of motivation with the request for outpatient care to hospitalauths@gems.gov.za . The healthcare team will review the request and provide an authorisation number if this is approved.

There is also the option of contacting the GEMS Provider Call Centre on 0860 436 777 or sending an email to hospitalauths@gems.gov.za to enquire further.

MATERNITY PROGRAMME

The GEMS Maternity Programme provides extensive support for pregnant members and their dependants throughout their pregnancy delivery, and post-natal care. Early registration will offer access to personalised care, expert advice, antenatal consultations, and tailored resources. It is important to ensure that the correct diagnosis (ICD-10 codes) is used when claiming to unlock the maternity benefits.

The Maternity Programme is headed by case managers who are experienced, registered nursing sisters with additional qualifications in midwifery who assist with registration and ongoing clinical and psychosocial support. For personalised advice and information, members can contact the team on 086 000 4367.

Early enrolment is recommended for the well-being of both mother and baby.

The benefits of joining the Maternity Programme

- You will be assigned a dedicated midwife who will provide you with telephonic support and information during each trimester of your pregnancy. You will continue to receive this support should you experience challenges in your first six weeks of parenthood.
- If you have a high-risk pregnancy, you will receive additional telephonic support from your midwife to help you manage and reduce the risks to you and your baby.
- You will receive a GEMS pregnancy handbook and a Maternity Programme guide.
- You will have access to healthcare information through telephonic interaction with your midwife and brochures, enabling you to make informed decisions with your midwife or doctor about your health and birth choices.
- A Maternity Care Plan Utilisation Guideline will be shared with you to inform you what is covered by the Scheme and how to best optimise your benefits.
- You will qualify for added maternity vitamins. For more information on the maternity vitamins, contact the GEMS Maternity Call Centre on 0860 00 4367 or visit www.gems.gov.za. Additional vitamins that are not part of the formulary list may incur additional out-of-pocket costs.

- We will send you a maternity bag during your third trimester. This is our gift to you filled with goodies for you and your baby.
- To view a comprehensive brochure about the Maternity Programme, visit www.gems.gov.za and navigate to Healthcare Providers > Healthcare Programmes > Maternity Programme.

Registering on the Maternity Programme

Telephonic registration:
You can complete your registration telephonically by contacting us on 086 000 4367.

Registration form:
Visit www.gems.gov.za to download and complete the registration form or call us on 0860 00 4367 to obtain a copy of the form. Once completed, please email the form to enquiries@gems.gov.za, or post it to Private Bag X782, Cape Town, 8000.

To access the maternity benefits, pregnant members or dependants must register for the programme as soon as their pregnancy has been confirmed.

		1st trimester	2nd trimester (13-26 weeks)					3rd trimester (27-40 weeks)			Post Natal
Benefit / Tariff Codes	**Services**	≤12 Weeks	13-15 Weeks	16 Weeks	20 Weeks	20-24 Weeks	26 Weeks	27-28 Weeks	32 Weeks	38 Weeks	41-42 Weeks
0000190/ 0000191, 000192, *88420	**GP/Midwife/Gynae-cologist Consultation** (Blood-Pressure, Weight, Height, Urine test) Two of the five second-trimester consultations can be used for gynaecological consultations	✔	✔	✔	✔	✔	✔				
0003755	Blood test: Full blood count-Haemoglobin test	✔				✔					
0003764	Blood test: Blood group with Rhesus	✔									
0003932	Blood test: HIV (Elisa or other screening test)	✔									
0003949	Blood test: Venereal Disease Research Laboratory (VDRL)	✔									
0004188	Macroscopic Urinalysis	✔	✔	✔	✔	✔	✔	✔	✔	✔	
As per the maternity vitamins list	Vitamins Supplements script	✔	✔	✔	✔	✔	✔	✔	✔	✔	
0003615	2D Ultrasound: **10 - 14 weeks** + nuchal trans-lucency assessment The member has the option of the following scans that will be paid to the value of a 2D scan: 3D Ultrasound: **10 - 14 weeks** + nuchal translucency assessment	✔									
0003617	2D Ultrasound: **20 - 24 weeks** + detailed ana-tomical assessment The member has the option of the following scans that will be paid to the value of a 2D scan: 3D Ultrasound: **20 - 24 weeks** + nuchal translucency assessment				✔						
0000190/ 0000191, 000192, *88420	**Gynaecologist/ Obstetrician Consultation** (Blood Pressure,Weight, Height, Urine test)										
Maternity Support	Trimester Calls	Expect 1st Trimester call	Expect 2nd Trimester call					Expect 3rd Trimester call			Expect Postnatal call
Maternity Info & Content	Welcome Pack, Trimester Brochure and SMSs	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔

Disclaimer

Every effort has been made to ensure that all information provided to you is factual and accurate. However, in the event of a dispute, the Scheme Rules shall apply. You can view the Scheme Rules on our website at www.gems.gov.za in the 'Information' section under Scheme Rules. The information provided on this correspondence is for information purposes only and cannot replace medical advice from your professional healthcare provider. The welcome letter that is received in the Welcome Pack supersedes the maternity care plan infographic.

DENTAL BENEFIT

The GEMS Dental benefit ensures that members have access to cost-effective, quality dental healthcare.

Benefit Option	Out-of-Hospital Dental Services Benefit
Tanzanite One	Two (2) treatment episodes per beneficiary per year; subject to the list of approved services*, managed care protocols and processes, and use of Dental DSP/Network. Specialised dentistry benefits are limited to PMBs only.
Beryl	Two (2) treatment episodes per beneficiary per year; subject to the list of approved services*, managed care protocols and processes, and use of Dental DSP/Network. Specialised dentistry benefits are limited to PMBs only.
Ruby	Shared dental limit of R4 489 per beneficiary per year for in-hospital dentistry professional fees and all out-of-hospital dentistry.
Emerald Value	Shared dental limit of R6 900 per beneficiary per year for in-hospital dentistry professional fees and all out-of-hospital dentistry.
Emerald	Shared dental limit of R6 900 per beneficiary per year for in-hospital dentistry professional fees and all out-of-hospital dentistry.
Onyx	Shared dental limit of R12 310 per beneficiary per year for in-hospital dentistry professional fees and all out-of-hospital dentistry.

*The GEMS Dental Provider Guide, which details the approved services and codes for dental health practitioners, can be found at www.gems.gov.za under Healthcare Providers> Healthcare Provider Guides.

Dental Health Practitioners:

GEMS recommends visiting your dental health practitioner every six months for a dental check-up and oral preventative care.

If you are on the **Tanzanite One or Beryl option,** dental services must be provided by a dentist, dental therapist, or oral hygienist on the GEMS dental network (i.e. T1B Dental Providers list).

If you are on the Ruby, Emerald Value, Emerald value, or Onyx option, consider visiting a dental health practitioner who is on the GEMS dental network to avoid unexpected out-of-pocket expenses. The agreed-upon Scheme tariffs are charged by GEMS dental network providers. If you have benefits for treatment, you will not have to pay anything out-of-pocket at a network provider. If any dental work is required that is not covered by GEMS, the network provider will first obtain your permission before proceeding with the treatment, with a cost discussion. This way, you will always know what dental bills to

You can find a network provider at www.gems.gov.za or by calling 0860 00 4367. Choose option 4, your preferred language, then option 2 for Dental, and option 3 for General Enquiries.

Emergency out-of-network visits for members on the Tanzanite One and Beryl options

Benefits on the Tanzanite One and Beryl options are subject to the use of a GEMS dental network provider. Members are allowed one emergency out-of-network visit per year for pain and sepsis treatment.

If there is no network provider in your area, call GEMS on 0860 00 4367 before going to the dentist to confirm if the visit is covered. This will help you avoid unexpected co-payments. Option 4 is your preferred language, followed by Option 2 for Dental, and Option 3 for General Enquiries.

Root canal treatment

Root canal treatment is covered on all options.

For Beryl and Tanzanite One members, this benefit is limited to one root canal treatment per beneficiary per year, and the services must be provided by a dentist on the GEMS dental network. For all other options, this benefit is subject to the available shared dental limit.

Preventative Care: Dental sealants

Enquire with your dental health practitioner about dental sealants for your child's permanent teeth. Dental fissure sealants are a simple and effective way to prevent tooth decay, and they are covered by your Preventative Care Services benefit if the service is received from a network provider.

The following treatments are covered from the Preventative Care Service benefit:

Benefit Option	Preventative Care Services
Tanzanite One	**Dental sealants:** Limited to beneficiaries under 18 years of age; and subject to the use of a Network provider; subject to managed care protocols and processes; paid at 100% of the Scheme Rate.
Beryl	**Dental sealants:** Limited to beneficiaries under 18 years of age; and subject to the use of a Network provider; subject to managed care protocols and processes; paid at 100% of the Scheme Rate.
Ruby	**Dental sealants:** Limited to beneficiaries under 18 years of age; and subject to the use of a Network* provider; subject to managed care protocols and processes; paid at 100% of the Scheme Rate. **Dental polishing:** Limited to beneficiaries between the ages of three (3) and nine (9) years; services may be rendered by a Network or Non-Network provider; paid at 100% of the Scheme Rate.
Emerald Value	**Dental sealants:** Limited to beneficiaries under 18 years of age; and subject to the use of a Network* provider; subject to managed care protocols and processes; paid at 100% of the Scheme Rate. **Dental polishing:** Limited to beneficiaries between the ages of three (3) and nine (9) years; services may be rendered by a Network or Non-Network provider; paid at 100% of the Scheme Rate.
Emerald	**Dental sealants:** Limited to beneficiaries under 18 years of age; and subject to the use of a Network* provider; subject to managed care protocols and processes; paid at 100% of the Scheme Rate. **Dental polishing:** Limited to beneficiaries between the ages of three (3) and nine (9) years; services may be rendered by a Network or Non-Network provider; paid at 100% of the Scheme Rate.
Onyx	**Dental sealants:** Limited to beneficiaries under 18 years of age; and subject to the use of a Network* provider; subject to managed care protocols and processes; paid at 100% of the Scheme Rate. **Dental polishing:** Limited to beneficiaries between the ages of three (3) and nine (9) years; services may be rendered by a Network or Non-Network provider; paid at 100% of the Scheme Rate.

*Should beneficiaries receive this treatment from a non-network service provider, the treatment will be paid from the shared dental limit, not the Preventative Care Services benefit.

Pre-authorisation for specialised dentistry

Members and dependants need pre-authorisation for the following treatment types:

- Any treatment in hospital.
- Conscious sedation, anaesthesia.
- Crown and bridge treatment.
- Implant-supported crowns, bridges and dentures.
- More than four (4) fillings (Beryl option).
- Orthodontics.
- Periodontal treatment.
- Plastic dentures (Tanzanite One and Beryl options).
- Surgical procedures: Removal of impacted teeth.
- Surgical procedures: Maxillofacial surgery.

To request pre-authorisation, ask your dental health practitioner to complete and submit the 'Periodontal' form (for Periodontal treatment) or the 'Dental Report' form (for all other treatments). The forms are available on www.gems.gov.za under Forms on the GEMS Information Centre page.

Dental treatment in hospital

Dental hospitalisation is only permitted for patients up to (and including) the age of six, for impacted teeth, or for severe trauma (PMBs).

Unless it is an emergency, contact us at least 48 hours before the treatment to request pre-authorisation for hospitalisation in a private facility. Failing to do so, a co-payment of R1 000 per admission will apply.

If a patient is admitted to a private facility for an emergency dental condition, the Scheme must be notified within one working day of the admission, otherwise, a co-payment of R1 000 per admission will apply.

If you are on the Tanzanite One or Emerald Value option, you must use a State or GEMS Hospital Network facility; failing which, the Scheme shall not be liable to fund the first R15 000 of any other facility's bill. You are encouraged to use a GEMS network hospital to avoid out-of-pocket expenses. You can view the list on the GEMS website at www.gems.gov.za or by calling 0860 00 4637.

Dental treatment under general anaesthesia or conscious sedation

Your dental health practitioner may inform you that your dental procedure will be performed under general anaesthesia or conscious sedation in certain circumstances and for certain procedures. You will be asleep throughout the procedure if you are given general anaesthesia. This is usually done in a hospital setting. Conscious sedation means that you are awake but relaxed during the procedure. This procedure is carried out in the dental chair.

All procedures requiring general anaesthesia or conscious sedation require pre-authorisation. Pre-authorisation may not be required in an emergency, but we recommend that you contact us as soon as possible to avoid paying a penalty. Before the procedure, the treating dentist or dental specialist must provide GEMS with the medical reason for general anaesthesia or conscious sedation.

Conscious sedation in the rooms
Conscious sedation in the rooms is only applicable to beneficiaries up to and including the age of nine (9) years, subject to pre-authorisation and managed care protocols and processes.

General anaesthesia
Benefits for treatment under general anaesthesia or conscious sedation are not available for members or dependants over the age of six (6) unless they have impacted teeth or have suffered

Surgical procedures
The Surgical Procedures benefit is available for maxillofacial surgery, and the removal of impacted teeth (in- and out-of-hospital):

Benefit Option	Surgical Procedures Benefit: Maxillofacial Surgery and Removal of Impacted Teeth
Tanzanite One	Paid at 100% of the Scheme Rate subject to the surgical procedures sublimit of R29 213 per family per year; limited to the use of State or Network facility or practitioners' rooms; claims paid at 200% of the Scheme Rate for approved procedures specified by managed care performed in practitioner's rooms instead of in the hospital. Subject to pre-authorisation*, managed care protocols and processes.
Beryl	Paid at 100% of the Scheme Rate subject to the surgical procedures sublimit of R29 213 per family per year; claims paid at 200% of the Scheme Rate for procedures specified by managed care performed in practitioner's rooms instead of in the hospital. Subject to pre-authorisation*, managed care protocols and processes.
Ruby	Paid at 100% of the Scheme Rate for authorised procedures performed in hospital*, or 200% of the Scheme Rate for procedures specified by managed care performed in practitioner's rooms instead of in the hospital.
Emerald Value	Paid at 100% of the Scheme Rate for authorised procedures performed in hospital*, limited to use of a State or Network facility; or 200% of the Scheme Rate for procedures specified by managed care performed in practitioner's rooms instead of in the hospital.
Emerald	Paid at 100% of Scheme Rate for authorised procedures performed in hospital*, or 200% of Scheme Rate for procedures specified by managed care performed in practitioner's rooms instead of in hospital.
Onyx	Paid at 100% of Scheme Rate for authorised procedures performed in hospital*, or 200% of Scheme Rate for procedures specified by managed care performed in practitioner's rooms instead of in hospital.

*State facilities are exempt from the requirement of obtaining hospital authorisation from the Scheme; however, providers in private practice who utilise state facilities still need to obtain pre-authorisation.

Dentures

Tanzanite One and Beryl options:

- The GEMS dental benefit allows for one set* of plastic dentures per beneficiary every four years.
- Only members and beneficiaries over the age of 21 qualify for this benefit.
- The benefit is subject to pre-authorisation, the use of a GEMS dental network provider, and is limited to the approved 2025 Scheme tariff.
- No benefit is available for metal frame dentures.

Ruby, Emerald Value, Emerald, and Onyx options:

- All denture-related claims are payable from the available shared dental limit at 100% of the Scheme rate.
- Members are allowed one set of plastic dentures per beneficiary every four years, with rebase and relines of the soft base every two years.
- Metal frames for partial dentures are limited to one per jaw, once every five years.

A set of dentures is defined as either one of the following:

- A full set (complete dentures – upper and lower).
- A complete upper or a complete lower denture.
- A partial upper and/or partial lower denture.
- A complete upper and partial lower denture.
- A complete lower and partial upper denture.

Registering on the Periodontal Programme

To be eligible for periodontal treatment benefits, Tanzanite One and Beryl members must enrol on the Periodontal Programme.

The Periodontal Programme is a disease management programme for patients with mild periodontitis. Once the treatment plan is approved, the enhanced benefits for dental cleaning and specialised treatment (such as root planning) will help prevent tooth loss.

Periodontal (gum) disease treatment is limited to local anaesthesia, with no coverage for in-hospital care.

Your GEMS dental network provider must complete the periodontal pre-authorisation form and forward it to GEMS along with the supporting documentation to enquiries@gems.gov.za. The Periodontal Form is available at www.gems.gov.za under For Individuals > Forms.

Orthodontic treatment

Ruby, Emerald Value, Emerald and Onyx options:

- GEMS does not have a separate benefit limit for Orthodontic treatment; all claims are payable from the available shared dental limit.
- Only members and beneficiaries under the age of 21 qualify for this benefit.
- Authorisation and a treatment plan are required, and approval is subject to prior evaluation according to the Index of Complexity, Outcome and Need (ICON) criteria.

- The duration of fixed Orthodontic treatment ranges from 9 to 36 months, depending on the complexity as explained in the treatment plan. The approval for the Orthodontic treatment plan is valid for one (1) year. An updated authorisation is required on an annual basis for the remainder of the treatment.
- Valid claims will be covered only if the beneficiary's GEMS membership is active and valid throughout the treatment period. Once approved, GEMS will pay the provider an initial amount, and the balance will be paid in monthly instalments, subject to the beneficiary's shared dental sublimit funds. If a case is transferred to another provider, only the remaining balance under the original treatment plan is covered.

Declined dental authorisations: Appeal process

If your application for pre-authorisation has been declined an appeal may be lodged with enquiries@gems.gov.za.

The appeal process can take up to 5 working days before a decision is sent to you. Kindly await the outcome of the decision before proceeding with the treatment.

Dental exclusions and limitations

Certain dental procedures have age requirements, and the number of dental procedures allowed per beneficiary in each period is limited.

These restrictions are detailed in the GEMS Dental Provider Guide, which can be found at www.gems.gov.za under Healthcare Providers> Healthcare Provider Guides. More information on Dentistry and Maxillofacial Surgery Exclusions can be found in Annexure E of the GEMS Scheme Rules.

Elective cosmetic dental procedures

Elective cosmetic dental procedures and complications arising from them are not covered by GEMS, unless such complications are PMBs.

Ex gratia process

As a GEMS member you are eligible for ex gratia assistance for dental treatment. Kindly await the outcome of the decision before proceeding with the treatment. Also, refer to 'The availability of ex gratia funding' in this guide for information on the ex gratia application process.

Optometry Benefit

The GEMS Optometry benefit provides you with clinically essential optometry benefits, covering the expenses necessary for your health and sight. You have the choice between glass or plastic lenses. GEMS pays according to the Scheme approved rates for optometry services, in line with industry funding guidelines, Scheme rules and the managed care protocols.

As outlined in the benefit schedule in the option-specific mini guide in the table below, there is a limit for your family, as well as a sub-limit for each beneficiary registered to the Scheme.

The benefit limits refer to the maximum amount that is available for your optical benefits. Keep in mind that sub-limits and rules may apply, potentially resulting in a benefit available per beneficiary lower than the overall optical limit.

Each beneficiary qualifies for an optometric examination (every 12 months), one pair of standard lenses and a frame or contact lenses (every 24 months). The Ruby Option benefits for frames or contact lenses are available every year from 1 January to 31 December of the same year, subject to Scheme rules, managed care protocols and available savings (PMSA).

The claim for each beneficiary is capped at a maximum of each sub-limit, and the total family claim is limited to the 'family limit.'

Benefit Option	Limit Available
Tanzanite One	Limit of **R 1 519** per beneficiary every two (2) years
Beryl	Limit of **R 1 924** per beneficiary every two (2) years
Ruby	Limited to PMSA and Block Benefit every financial year from 1 January to 31 December of the same year. The frame is limited to **R1 636**
Emerald Value	Annual family limit available of **R5 942** Limit of **R3 099** per beneficiary every two (2) years Frame is limited to **R1 636** For beneficiaries with Keratoconus, the family and beneficiary limits specified above shall be subject to an additional optometry booster benefit of **R2 751** per family per annum for scleral contact lenses, subject to a managed care process.
Emerald	Annual family limit available of **R5 942** Limit of **R3 099** per beneficiary every two (2) years The frame is limited to **R1 636** For beneficiaries with Keratoconus, the family and beneficiary limits specified above shall be subject to an additional optometry booster benefit of **R2 751** per family per annum for **scleral contact lenses**, subject to a managed care process.
Onyx	Annual family limit available of **R7 033** Limit of **R3 656** per beneficiary every two (2) years. Frame is limited to **R2 645** For beneficiaries with Keratoconus, the family and beneficiary limits specified above shall be subject to an additional optometry booster benefit of **R2 751** per family per annum for scleral contact lenses, subject to a managed care process.

For Example:

To illustrate how the benefit for a family works, let us explain the Emerald Option:

Claim received	2025 Overall Annual Family Limit: R5 942 (As at 1 January 2025); 2025 Beneficiary/dependant limit R3 099
Beneficiary 1 claims for R2 400.	The beneficiary limit for 2025 is **R3 099**, therefore **R699** will remain after the R2 400 claim is processed **(R3 099 – R2 400)** The family limit remaining after the **R2 400** claim is processed **will be R3 542** (Overall Family Limit - Claim Amount)
Beneficiary 2 claims for R3 099.	The family limit of **R3 542** after beneficiary 1's claim was processed is sufficient to cover beneficiary 2's claims with a balance of R443 that will be left in the family benefit. **(R3 542 - R3 099)**
Beneficiary 3 claims for R2 000.	This will be processed from the available family benefit (in this example **R433**). The balance of **R1 557** due will be out of pocket. The family limit of **(R5 942)** will be depleted for the year, considering that three members have had claims within the same benefit cycle.

The family limit is available each year on the Emerald, Emerald Value and Onyx options for beneficiaries who did not claim in the previous year.

Child Screening

Preventative health screening is one of the most important healthcare strategies to facilitate early diagnosis and treatment of disease as well as to improve quality of life.

GEMS offers a childhood Optometry screening benefit across all options for beneficiaries from 3 months up to and including age seven.

This is a once-in-a-lifetime benefit, paid from the preventative screening benefit, thus preserving the Optical benefit. Please ask your optometrist for more information.

The GEMS Optometry Network and how it works

GEMS members receive optometry services and materials, like spectacles and contact lenses, which are paid at a preferred rate from any GEMS network optometrist. This means that by visiting a GEMS network optometrist, you will receive services and items at a reduced rate. The GEMS Optometry Network consists of 98% of all optometry providers in South Africa, so your optometrist will likely be a network provider. To find your nearest GEMS network optometrist, please visit the GEMS website at www.gems.gov.za and use the following path: Healthcare Providers > Designated Service Providers.

Items that may not be covered by GEMS:

Not all items prescribed by your provider may be covered. Some of the items not covered include:

- Plano (zero power) and low power lenses for both eyes.
- Sunglasses and spectacles with lens tints exceeding 35%, except in cases of members living with albinism.
- GEMS covers either spectacles or contact lenses in an Optical Appliance Cycle of 24 months, not both.
- No bifocal or multifocal lenses for persons under the age of 40, unless clinically motivated by your optometrist.

- No contact lenses for children under the age of 16 should be motivated.
- Non-essential items, such as coatings.
- In some instances, a certified Optometrist may prescribe certain medications that GEMS does not cover. This may be excluded and, therefore, may not be paid or may be short paid by GEMS if the medicine is not on the GEMS-approved list of medicines covered.

Key reminders for members:

- Members are encouraged to always confirm their available benefits with their Optometrist as well as with the GEMS Optometry Team before services are accessed.

The GEMS Optometry Team can assist you with questions regarding your benefits on 0860 00 4367, select option number 4 for Optometry benefits. The Call Centre is available Monday to Friday from 08:00-17:00 and on Saturdays from 08:00-13:00.

Engage with your service provider to understand the prescription and ask questions to ensure that the prescribed items will be covered by the Scheme benefit. GEMS advises service providers of items that will be covered by sharing a pricing file annually. Where items are not covered, members should ensure that they will be able to pay for the additional items claimed. Members who change their benefit options should be aware that downgrading options may affect their Optometry benefit. Members are encouraged to discuss the change in option with their optometrist to identify potential shortfalls.

Alternatively, members can contact the Call Centre for assistance in understanding the benefits available on the new option plan. Before changing your option, ensure that the Optometry benefit for all dependants requiring optical services is adequate.

- Where children require spectacles, please note that additional records may be requested as part of the Optometry Managed Care Programme. Your optometrist will provide these records if required.
- Members cannot claim benefits after they are terminated from the Scheme. If your employment is terminated, your benefits at GEMS will end from the date of termination. To ensure that you have sufficient benefits, make use of a Network Provider who will assist you to choose spectacles up to the benefit limit, thereby avoiding possible out-of-pocket expenses for yourself.

THE WELLNESS PROGRAMME

The GEMS Health and Wellness Screening Services (HWSS) were created to combat the growing negative impact of illness on public servants' productivity.

The service is intended to be a positive experience, focusing on preventative measures such as assisting you with lifestyle changes. The GEMS HWSS has proven to be extremely beneficial, with encouraging results.

Only by testing your current health and well-being can you plan and implement meaningful and targeted interventions. We encourage you to take advantage of the GEMS Wellness Days that are available to you. The objectives of GEMS HWSS are aligned with creating a strong culture of well-being within the Government Departments and include the following:

- Providing Health Screenings for all Public Service employees.
- Early identification of lifestyle conditions (Diabetes, Hypertension), including HIV.
- Referral to GEMS Disease Management Programmes.
- Providing support and guidance to maintain your well-being (mental, psychological, and social) for optimal functioning in the workplace.
- Raising awareness of the importance of well-being and healthy living.

GEMS provides the following screening tests and services at Wellness events:

- Body Mass Index (BMI) assessment.
- Random Blood Glucose Testing.
- Blood Pressure Testing.
- Total Cholesterol Testing.
- HIV pre and post Counselling and Testing (HCT).
- Oral Health Education.
- TB Screening Questionnaire.
- Lifestyle questionnaire.
- Head, Neck, and Shoulder massages.

PREVENTATIVE CARE AND SCREENING BENEFIT

Preventative health screening is one of the most important healthcare strategies to facilitate early diagnosis and treatment of disease , to improve quality of life, and to prevent premature death. GEMS offers comprehensive screening and preventative care benefits to its members. These benefits are available on all options and payable from the risk-benefit for eligible members and beneficiaries as per the tabulated criteria below.

Screening services

Procedure	Tariff Codes	Tariff Description	Eligible Beneficiaries and Frequency	Disciplines Allowed
Cholesterol Screening	4027	Blood Cholesterol (finger prick)	Once per benefit year for all beneficiaries 20 years and older	General Medical Practice, Specialist Family Medicine
	0013	Blood cholesterol and/or triglycerides		Pharmacy
	99384	Cholesterol screening		Registered Nurses
Glucose Screening	4050	Blood glucose finger prick in rooms (Glucose strip-test with photometric reading)	Once per benefit year for all beneficiaries 20 years and older	General Medical Practice, Specialist Family Medicine
	0012	Blood Glucose		Pharmacy
	99370	Glucose Screening Test		Registered Nurses
Osteoporosis Screening Bone Densitometry scan	50120	X-ray bone densitometry	Once per benefit year for female beneficiaries who are 65 years and older	Radiologist
	3604	Bone densitometry (to be charged once only for one or more levels done at the same session)		Gynaecologist, Physician, Orthopaedics
	0190 - 0193	Consultation/visit		General Medical Practice, Specialist Family Medicine, Gynaecologist
	0201, 0202, 0210	Procedure codes: 0201- Cost of material 0202 – setting of sterile tray 0210 – collection of specimen		General Medical Practice, Specialist Family Medicine, Gynaecologist
	99385	Procedure code: Sterile tray and specimen handling fee		General Medical Practice, Specialist Family Medicine, Gynaecologist, Registered Nurses
Pap Smear screening	005,006,001, 002	Consultation	Once per benefit year for female beneficiaries who are 12 – 65years	Registered Nurses
	020,301	Procedure codes: 020 Specimen code 301 Consumables used		Registered Nurses
	4566	Vaginal or cervical smear		Pathologist, Medical Technology
	4559	Cytology preparation using approved liquid-based cytology method: first unit		Pathologist, Medical Technology
	CER1	HPV Polymerase chain reaction		Pathologist, Medical Technology
HIV and AIDS Pre-test Counselling (no test done)	7016	Pre-counselling	Once per benefit year, per beneficiary	General Medical Practice, Specialist Family Medicine
	0016	Pre-counselling (Without going ahead with the HIV test)		Pharmacy
	99376	HIV Pre-Test Counselling		Pharmacy

Procedure	Tariff Codes	Tariff Description	Eligible Beneficiaries and Frequency	Disciplines Allowed
Blood Pressure Monitoring	0015	Blood Pressure Monitoring	Once per benefit year for female beneficiaries who are 12 – 65years	Pharmacy
	99371	Blood Pressure Monitor		Registered Nurses
HIV and AIDS testing (screening test, post-test counselling, confirmatory test, and condoms)	7017	Pre-counselling, Screen test, Post-test counselling, Confirmatory test (all-inclusive code)	Once per benefit year, per beneficiary	Registered Nurses, General Medical Practice, Specialist Family Medicine
	0017	HIV and AIDS Testing and Post Counselling		Pharmacy
	99377	HIV and AIDS Testing and Post Counselling		Registered Nurses
Peak Flow measurement	0019	Peak Flow Measurement	Once per benefit year for beneficiaries 4 years and older	Pharmacy
	99383	Peak Flow Measurement		Registered Nurses
Mammography Screening	39175	Mammography: Unilateral or bilateral	Once per benefit year for female beneficiaries 40 years and onwards.	Radiography
	3934100	X-ray mammography including ultrasound		Radiography
	3605	Mammography: Unilateral or bilateral, including ultrasound and Doppler ultrasound examination, where necessary.		General Medical Practice, Specialist Family Medicine
Prostate Screening	4519	Prostate-specific antigen	Once per benefit year for male beneficiaries 45 – 69 years.	Pathologist, Medical Technology
Faecal Occult blood test	4352	Occult blood: Monoclonal antibodies	Once per benefit year for all beneficiaries 50 – 75 years.	Pathologist, Medical Technology
Neonatal Hypothyroidism	4507	Thyrotropin (TSH)	Once per neonatal beneficiary up to 28 days of age	Pathologist
Glaucoma Screening	11202	Tonometry (non-contact)	Once per benefit year for all beneficiaries 40 years and older.	Optometrists, Optical dispensers
	11212	Tonometry (Aplanation)		Ophthalmologist
	3014	Tonometry per test with a maximum of 2 tests for provocative tonometry (one or both eyes)		
	3017	Retinal threshold test inclusive of computer disc storage for Delta of Statpak programs		
	3018	Retinal threshold trend evaluation (additional to Item 3017)		
Pregnancy Screening	0018	Pregnancy Screening	Once per benefit year for a female beneficiary 12 years and older.	Pharmacy
	99381	Pregnancy Screening		Registered Nurses
Urine Analysis	0014	Urine Analysis	Once per benefit year for beneficiaries of all ages.	Pharmacy
	99382	Urine Analysis		Registered Nurses

Procedure	Tariff Codes	Tariff Description	Eligible Beneficiaries and Frequency	Disciplines Allowed
Childhood hearing screening for children	1010	Audiology consultation. Duration 5 - 15 mins	Once per beneficiary for the period from age one up to and including seven years.	Speech therapy and Audiology
	1011	Audiology consultation. Duration 16 - 30 mins		
	1115	Speech audiogram screening		
	1100	Pure Tone Audiogram (Air conduction) (3273)		
	1105	Bone conduction pure tone audiogram		
	1200	Tympanometry		
Childhood hearing screening for infants	1505	Diagnostic Audiological Click ABR (Auditory Brainstem Evoked Response) – Bilateral Air conduction threshold determination using click stimuli	Once per beneficiary for the period up to and including age 1 (but excluding beneficiaries in the first three months of life)	Speech therapy and Audiology
	1010	Audiology consultation. Duration 5-15 mins		
	1011	Audiology consultation. Duration 16 - 30mins		
	1580	Evoked otoacoustic emissions (OAE); limited		
Childhood optometry screening	94000	Individual Child Screening	Once per beneficiary for the period up to and including age seven (but excluding beneficiaries in the first three months of life)	Optometrist
Syphilis screening	3951	Quantitative Kahn, VDRL or other flocculation	Once per benefit year per beneficiary	Pathologist, Medical Technology
	3949	Qualitative Kahn, VDRL or other flocculation		
Chlamydia/ gonorrhoea screening	3946	IgM: specific antibody titre: ELISA/EMIT: per Ag	Once per benefit year per beneficiary	Pathologist, Medical Technology
	3948	IgG: specific antibody titre: ELISA/EMIT: per Ag		
	3923	Biochemical identification of bacterium: abridged		
	3925	Serological identification of bacterium: abridged		
	3960	Gonococcal, listeria or echinoccoccus agglutination		
TB screening	0221	Allergy: Skin-prick tests: Delayed hypersensitivity testing (Type IV reaction): Per antigen	Once per benefit year, per beneficiary (no age restriction)	General Medical Practice, Specialist Family Medicine, Pathologist
	Nappi 872938-027 Tuberculin PPD RT/23 Vial 1.5 ml)	Cost of material in treatment: This item provides for a charge for material used in treatment.		

Vaccinations from Preventative Care Services

Tariff code 0022 should be used for pharmacy administration of immunisation, 0017 for FP administration and 99378 for nurses. Disciplines allowed: 14, 15, 60, 61, 63, 88,110, and Specialists.

Procedure	Codes	Frequency	Eligible Beneficiaries
Influenza vaccination	3000826 Vaxigrip Tetra single dose 0.5ml pre-fill 732826 Influvac 0190-0193 consultation	Once per year	All beneficiaries ≥6 months of age
Pneumococcal vaccination	755826 Pneumovax 23 single dose vial 0.5ml 715858 Prevenar 13 pre-filled syringe 0.5ml	Once every 5 years	Once every 5 years for: high-risk beneficiaries between the ages of 2 and 64 with the relevant chronic or hospital admission. all beneficiaries 65 years and older irrespective of the chronic or hospital authorisation.
HPV vaccination	710020 Cervarix Pre-filled Syringe 0.5ml 710249 Gardasil Injection	One course per beneficiary per lifetime**	Females 9 - 45 years
COVID-19 vaccination	3002823 COVID-19 Vaccine Administration Fee		
	3003366 COVID-19 Vaccine Janssen	Three doses per beneficiary	18 years and older
	3003282 COVID-19 Vaccine Pfizer	Four doses per beneficiary *** Two doses per beneficiary ***	18 years and older 12 to 17 years
	3006073 COVID-19 Paediatric Vaccine Pfizer	Two doses per beneficiary***	5 to 11 years

A separate limit of R950 per beneficiary per year applies for vaccinations listed in the table below.

700356 Engerix-b	700210 Engerix-b*
700767 Hiberix	700513 Avaxim
700772 Priorix	701659 Heberbio hbv*
701658 Heberbio hbv	703442 Typherix
892939 Varilrix	703448 Havrix junior
3000689 Boostrix	703846 Dukoral
703994 Infanrix pre-filled	706829 Twinrix
707285 Infanrix hexa	713048 Euvax b*
710935 Rotateq	714999 Synflorix
711258 Tetraxim	717194 Vivaxim
713229 Adacel quadra	717466 Zostavax
714133 Rotarix liquid oral	719932 Hepatitis B (rdna) (adult)
715349 Euvax b	719933 Hepatitis B (rdna) (peadiatric)
716550 Priorix tetra	720708 Menactra
716655 Boostrix tetra	814970 Verorab**
719637 Hexaxim	814989 Stamaril
3002554 Measles vaccine	822361 Havrix 1440
722290 Measbio	822442 Typhim
723131 Onvara	832693 Tetavax
724016 Omzyta	3002364 Tetanus Vaccine Cipla Ampoule 0.5ml
823678 OPV-merieux 10	848905 Avaxim
823686 OPV-merieux 20	879460 Chirorab**
841307 OPV-merieux 10	3001925 Pneumovax 23
872962 BCG	3002510 Adacel Vial 0.5ml
879452 Morupar	

*Vaccinations must be pre-authorised.

Dental Services from Preventative Care

Procedure	Codes	Tariff description	Eligible Beneficiaries and Frequency	Disciplines allowed
Dental sealants	8163	Dental sealant: per tooth	• Limited to beneficiaries under 18 years of age • Maximum of 2 per quadrant in 12 months • Time rule of 1 per tooth in 730 days • Applicable to all permanent posterior teeth except 3rd molars (wisdom teeth)	• Pr 054, 095 and 113 • Dental Network providers only • Applicable to all options
Dental polishing	8155	Polishing - complete dentition	• All beneficiaries who are 3 to 9 years of age • Limitation of 1 in 180 days (2 in 12 months)	• Pr 054, 092,095 and 113 • Applicable to Ruby, Emerald, Emerald Value and Onyx options

Emergency Medical Services (EMS)

GEMS has an EMS network for ambulance services that provide emergency medical assistance to GEMS members.

How does the GEMS network work?

When a call is made to the emergency telephone number 0800 44 4367 (Option 1) or 0860 00 4367 (Option 1), the Emergency Medical Evacuation Dispatch (EMED) Contact Centre assigns the appropriate EMS provider with the required level of care for the incident. The EMED Contact Centre may be contacted twenty-four (24) hours a day, seven (7) days a week.

EMS includes:

- Assistance given to members over the phone when there is a medical emergency, whilst waiting for the ambulance to arrive at the scene.
- Emergency medical response (ambulance and emergency personnel) will be dispatched by road and/or air to the scene of a medical emergency.
- Transfer by road or air to the nearest, most appropriate medical facility.
- Transfer of a patient from one hospital facility to another where medical intervention is required.

EMS does not include:

Any ambulance transportation for conditions that are not a medical emergency, or where the ambulance service is used purely as a means of transportation from one place to another.

This may include, but is not limited to the following types of scenarios:

- A member who is pregnant and is in normal-term labour with no complications during the pregnancy and the labour.
- Any transportation to a home address or an old age home without prior authorisation from the EMED Contact Centre.
- Transportation to a doctor's room for an appointment or for the purpose of an X-ray where no medical emergency or authorisation exists.
- Transportation for a procedure that could be done at the current medical facility. An authorisation process will need to be followed to understand the motivation for the transportation to be considered.

- Transportation from a home address or step-down facility to a booked procedure or doctor's visit.
- Transportation for dialysis or oncology treatment without authorisation from the EMED Contact Centre.
- Transportation for any other reason other than that the referring medical facility cannot manage the patient.

The steps below may be followed when you are faced with a medical emergency:

- Contact the EMED Contact Centre for ambulance services by dialling 0800 44 4367 (Select Option 1) or 0860 00 4367 (Select Option 1).
- Provide your name and the contact number that you are calling from to the EMED Call Centre Agent.
- Provide the EMED Call Centre Agent with the address or location of the incident to help paramedics get to the incident scene. You will need to provide as much detail of landmarks or points of interest (e.g., name of school or church, street) if the actual address is unknown.

- Provide a brief description of what has happened and how serious the incident is, for example:
  - Is the patient breathing?
  - Is the patient conscious?
  - Brief details about the current condition of the patient e.g., is the patient actively bleeding?
- Provide any other information observed or the known medical history of the patient.
- Confirm the patient's GEMS membership number and the patient's name as written on the GEMS membership card.
- Do not put the phone down until the EMED Call Centre Agent has disconnected.

PLEASE NOTE: To avoid co-payments payable to ambulance services, please ensure that you make use of the GEMS emergency medical service number 0800 44 4367 (Select Option 1) or 0860 00 4367 (Select Option 1) for any medical emergency incidents. Members are encouraged to share this number with all relevant family members, friends, etc., for use during times of legitimate need.

CHANGING YOUR BENEFIT OPTION

You can only change your benefit option at the end of every calendar year. For option changes at any other time, you will need special permission from the Scheme. A notice period will be applied.

For more information, please see our Scheme Rules 16.2.2 and 16.2.3 at www.gems.gov.za. GEMS will send you information on any new benefits as well as the Option Selection form to help you decide whether to change options during the annual Option Selection period. If you change your option during the specified election period, your membership for the new option will begin on 1 January of the following year.

You do not need to complete an Option Selection form if you choose to stay on the same option. However, if your personal details have changed, the option form is a handy way of making sure that we have your most recent contact details. It is important that you submit your option change request by the deadline provided.

GOVERNANCE OF THE SCHEME

In addition to the Scheme's Board of Trustees and Executives, there are seven committees of the Board that oversee the work done in various areas.

These committees perform their duties with your interests in mind and ensure that the decision-making processes and structures are effectively governed. They are:

Audit Committee (AC)

The Board of Trustees, in terms of section 36(10) of the Medical Schemes Act 131 of 1998, are required to appoint an Audit Committee of at least five (5) members, of which at least two (2) shall be members of the Board of Trustees. The remaining three (3) members must be independent of the Board, including the Chairperson. An Audit Committee Charter that provides guidance to its members determines its authority and duties. The AC's primary responsibilities include assisting the Board of Trustees to evaluate the adequacy and efficiency of the Scheme's internal controls, accounting practices, financial reporting processes and its risk management.

The committee's other responsibilities include overseeing the Scheme's information systems, providing oversight on external reports (other than financial statements), and guiding the combined assurance processes applied by the Scheme and its service provider network. The Audit Committee considers and recommends the appointment of external auditors, monitors them and reports on their independence to the Board. The committee is also responsible for appointing and assessing the performance of the Chief Audit Executive. They also approve the internal audit plan, the annual review, and the approval of the Internal Audit Charter.

Clinical Governance and Administration Committee (CGAC)

The primary responsibility of this committee is to assist the Board of Trustees in ensuring that the operations of the Scheme are efficient by providing oversight and assessment and review processes of all the administrative aspects of the Scheme. The committee assists the Board of Trustees to ensure that there is seamless interaction between the various service providers to meet the operational objectives of the Scheme. The committee also assists the Board to expand the Scheme's membership, and is involved in overseeing communication and marketing activities, stakeholder relations and managing the complaints management function with the view to:

- Assess and report on the approval of ex gratia applications and payments to members of the Scheme. The committee has the mandate to approve ex gratia payments of more than R50 000.00 and to intervene in matters where a patient cannot obtain treatment/therapy (due to insufficient cover) or may be facing a life-threatening condition, or when the treatment prescribed for the patient will result in them leading an improved quality of life. Members will be assisted if the treatment/therapy prescribed for their condition is clinically safe, is supported by internationally recognised medical evidence and meets the treatment guidelines. The Scheme may also assist in cases where the patient has a proven inability to afford the required treatment. However, these cases are dealt with on a case-by-case basis and depend on the financial allocation for such projects.
- Assist the Board to ensure that the Healthcare Management Strategic Objectives are implemented, specifically: To improve the Scheme's clinical risk profile and limit fraudulent claims.
- Oversee the Scheme's product development process.

Risk Social and Ethics Committee (RSEC)

This committee has been mandated by the Board of Trustees to ensure sound corporate governance controls by providing oversight, assessment, and review of the Risk Management Policy and maintaining ethics and compliance within the Scheme. The committee must comply with the Medical Schemes Act's regulations, patent and trademark legislation and deal with any legislative matters in the Scheme.

Finance and Investment Committee (FIC)

The committee was established by the Board in December 2013 and their primary responsibility is to assist the Board to fulfil its mandate to deal with the Scheme's investment activities and consider issues relating to GEMS' investment activities. This committee monitors the Scheme's organisational and financial performance. The Scheme's responsibility to review the contracts of its service providers on a regular basis also lies with the committee. The committee monitors the Scheme's cash flow position, performance of investments and GEMS' compliance with the regulatory framework in respect of Medical Scheme investments. The committee also oversees the Scheme's Information and Communication Technology (ICT) infrastructure, communication function and monitors the performance of asset consultants and managers contracted to the Scheme.

Dispute Committee (DC)

The primary responsibility of this committee is to consider and preside over any disputes referred by the Principal Officer (PO) to the DC for adjudication. The DC provides independent advice to the Board of Trustees on how to handle disputes within the Scheme.

On 29 April 2019, the GEMS Board of Trustees approved a recommendation to move away from the current DC structure to an alternative dispute resolution body (e.g., an Ombud).

Human Resources and Remuneration Committee (HRRC)

This committee seeks to ensure professional and sound people management within the Scheme by assessing and reviewing relevant HR and remuneration policies. The committee advises the Board about the annual cost of living adjustment for the Scheme's employees. The committee formulates the criteria used to benchmark annual remuneration surveys and the applicable remuneration rates for employee levels, trustees, and independent committee members.

The committee also implements the remuneration survey results or recommendations, performance review measures for the Scheme's employees and discloses the remuneration earned by trustees, independent committee members, and members of the GEMS Executive Committee in the Scheme's annual integrated report.

Benefit Design Committee (BDC) (complements the Standing Committee)

This committee deals with the benefit design for the Scheme and its annual contribution rates. The committee meets at least twice a year. The work commences with a product development process which runs throughout the year, in preparation for the GEMS BDC recommendation.

GEMS SERVICE PROVIDERS

We have contracted a network of service providers from administrative and operational services to provide quality healthcare.

- DENIS – Ambulatory dental managed care services.
- Europ Assistance – Emergency Medical Evacuation Dispatch (EMED) contact centre.
- Health Calibrate – Provider network management.
- Performance Health – Clearing House.
- Medipost Pharmacy and Marara Pharmacy – Chronic medicine courier pharmacies.

- Medscheme – Contributions and debt management services
- Medscheme – Managed care services
- Metropolitan Health – Correspondence services
- Metropolitan Health – Membership and claims services
- Aid for Aids – HIV management
- Opticlear – Optometry management services
- Tshela Healthcare – Maternity services
- Universal Healthcare – Pharmacy Network Management Provider (PNMP)

GLOSSARY (WORD LIST)

Acute Medicine
Medicine prescribed to relieve symptoms of a temporary illness or condition, for example, an infection or a sprain.

Additional Chronic Disease List (aCDL)
An additional list of chronic diseases that the Scheme provides chronic medicine benefits for. GEMS covers these diseases for some of its options, in addition to the 26 diseases that it must cover by law (the 26 diseases are given in the chronic disease list).

Appliance List
The appliance list is a list of medical appliances and devices which are funded by GEMS. Your provider may select the appropriate appliance or device from this list for your healthcare needs.

Beneficiary
A person who can receive benefits from GEMS. A beneficiary is either the main member on GEMS or one of their registered dependants.

Benefit
The amount of money allocated by GEMS to a member or dependant to spend on medical treatment and medicine, according to the relevant Scheme option: Tanzanite One, Beryl, Ruby, Emerald Value, Emerald, or Onyx.

Chronic
A chronic condition is any condition which needs ongoing treatment, or a treatment for a period of at least three months. Examples of chronic conditions are Asthma or Diabetes.

Chronic Disease List (CDL)
A list of the 26 specific chronic diseases all medical schemes need to provide a minimum level of cover for, as stated by law.

Conscious Sedation
A combination of medicine to help you relax and to block pain during a medical or dental procedure, during which you will probably stay awake but may not be able to speak.

Consultation
A visit to your doctor, or other healthcare provider to get a diagnosis or treatment. This also includes the times when your healthcare provider visits you while you are in hospital.

CT and MRI Scans
Specialised and more advanced type of 'X-rays.'

Designated Service Provider (DSP)
A healthcare provider or group of providers chosen by the Scheme to provide diagnosis, treatment and care to members for one or more PMB conditions. This includes doctors, pharmacies, and hospitals. When you choose not to use a DSP, you may have to pay a 30% portion of the cost of the consultation of treatment from your own pocket, depending on your option. For example, GEMS has a network of renal facilities as their DSP for renal dialysis. When you choose to use a non-network facility for chronic renal dialysis, a 30% co-payment will apply.

Formulary
The list of approved medicine, tests or services.

GEMS Tariff
The rate at which healthcare providers will be paid for services rendered to GEMS members.

GEMS Networks
GEMS has contracted with various providers to deliver quality healthcare to members at Scheme rates. Members on the Tanzanite One and Emerald Value options must make use of network providers for their healthcare needs in order to avoid co-payments.

General Anaesthesia
A treatment with certain medicine that puts you into a deep sleep, so you do not feel pain during a procedure. When you receive these medicines, you will not be aware of what is happening around you.

Family Practitioner (FP)
FPs are doctors who provide general healthcare services. It is important to always consult the same FP so that your FP can develop a good understanding of your health and treatment history. They can then make informed decisions about your care, such as if you need to be referred to a specialist.

Generic Medicine
Medicine that has the same chemical ingredient, strength and form (such as a tablet or syrup) as the original brand name product. Generic medicine is as safe and effective as the original brand name product but is usually more cost effective.

ICD-10 Code
These are codes that appear on healthcare provider accounts. The codes are used to inform medical schemes about what conditions their members were treated for so that claims can be settled correctly.

Main Member
The main/principal member registered on the Scheme.

Medicine List or Formulary
A list of cost-effective medicine that guides the doctor in the treatment of specific medical conditions.

Medicine Exclusion List (MEL)
A list of medicines that GEMS does not cover for various reasons.

Medicine Price List (MPL)
A reference pricing system used to work out the prices of groups of medicine. The medicines are grouped according to how similar they are in ingredients, strengths and form. If a member and healthcare provider chooses to use medicine that costs more than the reference price, the member pays the difference.

NAPPI Code
The National Pharmaceutical Product Index (NAPPI) is a comprehensive database of medical products used in South Africa. The NAPPI code is a unique code for medicines, medical appliances and consumable products. Your healthcare provider must include this code on all claims as it enables GEMS to identify what has been supplied.

Personal Medical Savings Account (PMSA)
The portion of your monthly contribution that is allocated to a savings account held in your name. The money in this account is used to pay for your out-of-hospital medical expenses on the Ruby option.

CONTACT DETAILS

GEMS Contact Centre
General queries related to GEMS
Toll free number 0800 00 4367
enquiries@gems.gov.za

Chronic medicine management new registrations and updates
Chronic registrations
0860 436 777
chronicdsp@gems.gov.za

Queries of claims
Queries relating to a claim for GEMS beneficiary
0800 00 4367
enquiries@gems.gov.za

GEMS website
View GEMS products and services
www.gems.gov.za

Chronic medicine authorisation queries
Queries related to the authorisation of chronic medicines
0860 436 777
chronicauths@gems.gov.za

Oncology services
Oncology-related queries
0860 436 777
oncologyauths@gems.gov.za

GEMS tariff file, formularies and forms
To view GEMS tariff file, formularies and forms
www.gems.gov.za, select Healthcare Providers > Tools > Select either Tariff file, ICD10 Codes or Forms from the menu.

Fraud Hotline
Fraud-related matters
0800 212 202
gems@thehotline.co.za
office@thehotline.co.za

Ambulatory PMB
Ambulatory PMB queries
0860 436 777
enquiries@gems.gov.za

GEMS network contract management and Provider Liaison Consultants
Contracting queries, REPI2 categorisation queries or Provider Liaison Consultant assistance
Ruby, Emerald & Onyx , TANZANITE ONE and BERYL: networkscontracting @gems.gov.za

Hospital pre-authorisation
All hospital and alternative to hospital pre-authorisations for non-emergency events
0860 436 777
hospitalauths@gems.gov.za

HIV/Aids management
HIV/AIDS related queries
0860 436 736
hiv@gems.gov.za

CONTACT DETAILS:

GEMS TOLL-FREE - 0860 00 4367

WEB - www.gems.gov.za

FAX - 0861 00 4367

EMAIL - enquiries@gems.gov.za

POSTAL ADDRESS - GEMS, Private Bag X782 Cape Town, 8000

GEMS FRAUD HOTLINE - 0800 212 202
gems@thehotline.co.za

GEMS EMERGENCY SERVICES - 0800 44 4367

Client Liaison Office (CLO)

Driving empowerment through education.

The CLO unit drives member education sessions and workshops to empower members and improve understanding of benefits, Scheme rules and processes.

If you would like one of our CLOs to visit your department, please send an email to **clo@gems.gov.za**

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LINKEDIN
Government Employees Medical Scheme

GPAD

Disclaimer

This brochure contains a summary of the healthcare benefits offered by GEMS for the year 2025 and the required monthly contributions/premiums associated therewith ("2025 GEMS Benefits and Contributions").
The 2025 GEMS Benefits and Contributions forms part of the GEMS Rules, which have been approved by the Council for Medical Schemes ("CMS"). In the event of a discrepancy between the wording of this brochure and that of the published GEMS Rules, the latter will take precedence. For the full version of the 2025 GEMS Benefits and Contributions, kindly refer to Annexures B, C, D, E, F and G of the GEMS Rules, which may be found on the GEMS website at **www.gems.gov.za.** You may also contact us directly on **0860 00 4367** to request a copy.