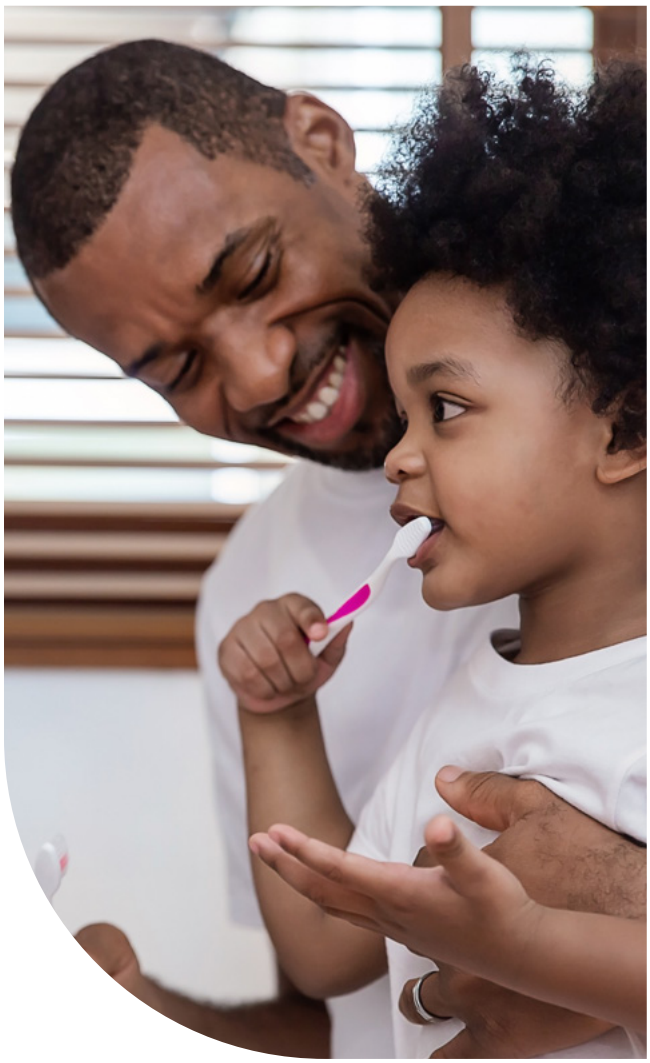
gems
Government Employees Medical Scheme

YOUR 2024 DENTAL PROVIDER GUIDE



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Introduction

GEMS relies on you, as a valued dental healthcare practitioner, to achieve the Scheme's objective of ensuring that members have access to cost-effective, quality dental healthcare.

This guide will provide you with the 2024 GEMS dentistry benefits and the Scheme's dental managed care rules. These include time and age rules, general principles and exclusions. The guide also stipulates how the rules are applied to various dental procedures and the specific application to the different GEMS options, namely Tanzanite One, Beryl, Ruby, Emerald Value, Emerald and Onyx.

NOTE:
Should you have any queries on benefits, rules, exclusions, pre-authorisation or your patient's Scheme option, please contact 0860 436 777 or send an email to **enquiries@gems.gov.za.**

GEMS Dental Network

High-quality clinical and administrative services is a team effort between the Scheme and healthcare providers. If you are a dentist, dental therapist or oral hygienist, GEMS invites you to become an integral part of this team by joining the GEMS Dental Network and Friends of GEMS.

For details and assistance on joining the growing network, please contact **0860 436 777** or send an email to **enquiries@gems.gov.za.**

GEMS Hospital Network

- Members on the Tanzanite One and Emerald Value options are subject to the use of a hospital in the GEMS Hospital Network or a state facility; failing which, the Scheme shall not be liable to fund the first R15 000 of the non-network hospital or facility's bill. This co-payment for Tanzanite One and Emerald Value members takes effect for any elective or voluntary use of a non-network hospital or facility. The GEMS Network Hospital list is available at **www.gems.gov.za**
- Members on the Beryl, Ruby, Emerald, and Onyx options can use private or state facilities for approved elective procedures.
- For PMB-related services in hospital, members on the Beryl, Ruby, Emerald, and Onyx options are subject to the use of state facilities and providers on the GEMS Dental Network, and in the case of Tanzanite One and Emerald Value members, state facilities or a hospital in the GEMS Hospital Network, and providers on the GEMS Dental Network.

Patient Registration and **Pre-authorisation**

Patient registration

During the patient's first visit to your practice, a once-off dental charting and full oral examination in association with code 8101 (as per normal prescribed guidelines for charging of code 8101) needs to be performed and then submitted to GEMS.

The 'Dental report' form for patient registration should be completed and sent to the Scheme. This facilitates centralised capturing of the patient's existing oral health status to ensure proper and appropriate dental managed care and risk management in accordance with internationally recognised standards. It also allows the Scheme to compile an actual and dynamic epidemiologic database of its patient population for future benefit and budgetary planning.

Pre-authorisation and/or a treatment plan

This is required for certain dental procedures as indicated in the procedure schedules in this guide pertaining to each option. They include certain specialised and surgical procedures, orthodontics, periodontal treatment, and any procedures to be performed in an operating theatre (general anaesthesia) or under conscious sedation.

Hospital authorisation for admission to a private facility (including facilities on the GEMS Hospital Network list and non-PMB one-day admissions) must be obtained from the Scheme's managed care service provider at least 48 hours before a beneficiary is admitted to a private facility (except in the event of an Emergency Medical Condition), failing which, a co-payment of R1 000 per admission shall apply.

In the event of an admission to a private facility for an Emergency Medical Condition, the Scheme must be notified of such admission within one (1) working day after the admission, failing which, a co-payment of R1 000 per admission shall apply.

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

Where pre-authorisation is required for periodontal treatment, the 'Periodontal' form should be completed and forwarded to the Scheme.

Where pre-authorisation and/or treatment plans are required for other dental procedures, the standard 'Dental report' form should be completed. It is necessary to complete only the applicable sections – for instance, it is not necessary to complete the charting section with each request, and it can be used until the completion of a treatment plan.

NOTE: The 'Dental report' and 'Periodontal' forms are available at **www.gems.gov.za**. Email the completed forms to **enquiries@gems.gov.za** or fax to **0861 00 4367**.

Access to **benefits**

- GEMS members have access to benefits as set out in this guide, subject to time and age rules, general industry principles and Scheme exclusions.
- Valid claims are paid at the agreed tariff subject to the availability of the dental benefit. Members will be liable for claims incurred on benefits falling outside the benefit schedule.
- Valid claims will only be covered if the beneficiary's GEMS membership is active at the time of treatment. Where back-dated terminations are imposed, the termination may result in reversal of claims.

Also refer to *"Member verification and validation"* and *"Non-disclosure and Underwriting"*.

Tanzanite One and Beryl: General administration, benefits and procedures covered

Tanzanite One and Beryl - Summarised Benefit Specifications and Specific Rules that apply

Benefit Specifications	Tanzanite	Beryl
Essential dentistry	Approved services/codes are covered at 100% of the agreed tariff subject to availability of the benefit.	Approved services/codes are covered at 100% of the agreed tariff subject to availability of the benefit.
GEMS Dental Network provider	Services must be provided only by a dental healthcare practitioner that is part of the GEMS Dental Network for the Tanzanite One and Beryl options.	Services must be provided only by a dental healthcare practitioner that is part of the GEMS Dental Network for the Tanzanite One and Beryl options.
Out-of-network visit	One (1) emergency out-of-network visit per beneficiary per year.	One (1) emergency out-of-network visit per beneficiary per year.
Emergency dentistry	• One (1) emergency out-of-network visit per beneficiary per year. • Emergency pain and sepsis treatment, including root canal treatment as per table of benefits. • Other treatment codes covered – 8201 (extraction of tooth or exposed tooth roots), 8307 (pulp amputation, pulpotomy), and 8132 (pulp removal, pulpectomy). • Any additional treatment requires funding by patient.	• One (1) emergency out-of-network visit per beneficiary per year. • Emergency pain and sepsis treatment. • Treatment codes covered – 8201 (extraction of tooth or exposed tooth roots), 8307 (pulp amputation, pulpotomy), and 8132 (pulp removal, pulpectomy). • Any additional treatment requires funding by patient.
Examinations and preventative treatment	Two (2) consultation/examination and preventative treatment episodes per beneficiary per year.	Two (2) consultation/examination and preventative treatment episodes per beneficiary per year.
Restorative treatment	• Limited to four (4) restorations per beneficiary per year, once per tooth in 720 days.	• Limited to four (4) restorations per beneficiary per year, once per tooth in 720 days. • Pre-authorisation needed for more than four (4) fillings.

Benefit Specifications	Tanzanite	Beryl
Root canal treatment	• Root canal therapy is limited to one (1) complete event per beneficiary in 12 months. • An event relates to only one (1) root canal treatment on one (1) tooth per beneficiary per year. • Services must be provided by a GEMS Dental Network provider only. • No benefit for specialist dental disciplines. • No benefit for retreatment of a previously root canal treated tooth.	• Root canal therapy is limited to one (1) complete event per beneficiary in 12 months. • An event relates to only one (1) root canal treatment on one (1) tooth per beneficiary per year. • Services must be provided by a GEMS Dental Network provider only. • No benefit for specialist dental disciplines. • No benefit for retreatment of a previously root canal treated tooth.
Specialised dentistry benefit	No specialised dentistry benefit – limited to PMB's.	No specialised dentistry benefit – limited to PMB's.
Surgical procedures: Maxillofacial surgery, and surgical removal of impacted teeth under general anaesthesia or conscious sedation in the rooms.	• Subject to an annual sublimit of R27 928 per family. • Subject to Scheme rules, relevant managed care protocols and pre-authorisation. • 200% of Scheme Rate for surgical removal of impacted teeth if authorised under conscious sedation in the rooms.	• Subject to an annual sublimit of R27 928 per family. • Subject to Scheme rules, relevant managed care protocols and pre-authorisation. • 200% of Scheme Rate for surgical removal of impacted teeth if authorised under conscious sedation in the rooms.
General anaesthesia	General anaesthesia only applicable to Beneficiaries: • up to and including the age of six (6) years for services classified as conservative or restorative per tariff code; • severe trauma; or • removal of impacted teeth. Subject to Scheme rules, relevant managed care protocols and pre- authorisation. (For impacted teeth, refer to *Surgical procedure: Maxillofacial surgery and surgical removal of impacted teeth under general anaesthesia*)	General anaesthesia only applicable to Beneficiaries: • up to and including the age of six (6) years for services classified as conservative or restorative per tariff code; • severe trauma; or • removal of impacted teeth. Subject to Scheme rules, relevant managed care protocols and pre- authorisation. (For impacted teeth, refer to *Surgical procedure: Maxillofacial surgery and surgical removal of impacted teeth under general anaesthesia*)
Conscious sedation in the rooms	Conscious sedation in rooms: • Only applicable to Beneficiaries up to and including the age of nine (9) years; subject to pre-authorisation and managed care protocols and processes.	Conscious sedation in rooms: • Only applicable to Beneficiaries up to and including the age of nine (9) years; subject to pre-authorisation and managed care protocols and processes.

Benefit Specifications	Tanzanite	Beryl
Hospital network	Yes, Hospitalisation subject to use of state or network hospital; failing which, the Scheme shall not be liable to fund the first R15 000 of the non-network hospital's bill. The GEMS Network Hospital list is available at **www.gems.gov.za**	No network applicable for pre- authorised procedures. For PMB, state facilities are the Designated Service Provider (DSP).
Radiology	All the following services subject to an approved list of tariff codes, managed care protocols and processes: • Panoramic X-rays are limited to one (1) per beneficiary every three (3) years; • Periapical X-rays are limited to six (6) per beneficiary per annum; • Bitewing X-rays are limited to four (4) per beneficiary per annum; and • Cone Beam Computed Tomography (CBCT) scans are limited to one (1) per beneficiary per lifetime for surgical procedures as per specified codes, subject to the provider being registered for CBCT.	All the following services subject to an approved list of tariff codes, managed care protocols and processes: • Panoramic X-rays are limited to one (1) per beneficiary every three (3) years; • Periapical X-rays are limited to six (6) per beneficiary per annum; • Bitewing X-rays are limited to four (4) per beneficiary per annum; and • Cone Beam Computed Tomography (CBCT) scans are limited to one (1) per beneficiary per lifetime for surgical procedures as per specified codes, subject to the provider being registered for CBCT.

CHARTING: Please note that as part of code 8101, a once-off patient charting and oral examination will be required for each beneficiary visiting your practice for the first time. The charting is to be submitted to the Scheme on the 'Dental report' form.

Tanzanite One and Beryl – Specific Rules that apply to Dentures

Benefit Specifications	Tanzanite	Beryl
Dentures	• Plastic dentures subject to pre-authorisation. • Only members and beneficiaries over the age of 21 qualify for this benefit. • One (1) set* of plastic dentures allowed once per beneficiary per 48-month benefit cycle. • No benefit for metal frame dentures. • Plastic dentures limited to the approved 2024 Scheme tariff.	• Plastic dentures subject to pre-authorisation. • Only members and beneficiaries over the age of 21 qualify for this benefit. • One (1) set* of plastic dentures allowed once per beneficiary per 48-month benefit cycle. • No benefit for metal frame dentures. • Plastic dentures limited to the approved 2024 Scheme tariff.

***A set of dentures is defined as follows:**

- A complete upper and/or a complete lower denture, or
- A partial upper and/or a partial lower denture.

The following table details the reimbursement codes for dentures:

Denture Codes Funded	Denture Codes Not Funded
8231 (complete dentures – maxillary and mandibular)	8658 (interim complete denture)
8232 (complete dentures – maxillary or mandibular)	8659 (interim partial denture)
8233 (partial – one (1) tooth) to 8241 (partial denture – nine (9) or more teeth)	8661 (diagnostic dentures)
8269 (repair of a denture or other intraoral appliance)	8244 (immediate upper denture)
8271 (add tooth to existing partial denture)	8245 (immediate lower denture)
8273 (impression to repair or modify a denture, or other removable intraoral appliances)	8281, 8663, and 8671 (metal base codes) and associated laboratory fees
8259 (rebase complete or partial denture – laboratory)	8099 (dental laboratory service)
8263 (reline complete or partial denture – intraoral)	
9-codes (individual laboratory codes)	

- When claiming via Electronic Data Interchange (EDI), use individual codes (i.e. 9-codes) for dental laboratories. Laboratory invoices to be retained by the practice for possible auditing.
- When submitting paper claims, use individual codes (i.e. 9-codes) for dental laboratories, and submit the dental laboratory invoice together with the paper invoice.
- No claim will be accepted without the professional fee and laboratory codes submitted together or being matched if a laboratory performs self-billing.

NOTE: No additional cover if dentures are lost due to negligence. A motivation is required for the replacement of dentures in other scenarios. Please direct all motivations to the GEMS call centre on **0860 436 777** or send an email to **enquiries@gems.gov.za.**

Tanzanite One and Beryl – Specific Rules that apply to Periodontal treatment

Benefit Specifications	Tanzanite	Beryl
Periodontal treatment	• Benefit for Periodontal treatment is subject to member's registration on the Periodontal Programme, pre-authorisation, and managed care protocols and processes apply. • Additional scaling and polishing benefit is allowed for beneficiary registered on the Periodontal Programme. • Services must be provided only by a dental healthcare practitioner that is part of the GEMS Dental Network for the Tanzanite One and Beryl options. • Limited to non-surgical periodontal treatment. • No benefit for specialist dental disciplines.	• Benefit for Periodontal treatment is subject to member's registration on the Periodontal Programme, pre-authorisation, and managed care protocols and processes apply. • Additional scaling and polishing benefit is allowed for beneficiary registered on the Periodontal Programme. • Services must be provided only by a dental healthcare practitioner that is part of the GEMS Dental Network for the Tanzanite One and Beryl options. • Limited to non-surgical periodontal treatment. • No benefit for specialist dental disciplines.
Periodontal Programme	• Benefit for periodontal treatment is subject to pre-authorisation and registration on the Periodontal Programme. • The following records are required for registration: - Community Periodontal Index (CPI) - Clear X-rays of the affected areas (taken within the last 3 months) - Maintenance plan (8159 or 8180 with the period of follow up, e.g. three (3) monthly or four (4) monthly) • Complete the 'Periodontal' form and forward to the Scheme along with the supporting records. • The benefit is subject to adherence to the approved maintenance plan.	

The following table details the reimbursement codes for the Periodontal Programme:

Periodontal Codes Funded	Periodontal Codes Not Funded
8176 (periodontal examination/screening)	8723 (provisional splinting – intracoronal, per dental unit included in the splint)
8179 (polishing – complete dentition, periodontally compromised patient)	8725 (provisional splinting – extracoronal, wire with resin, per sextant)
8180 (scaling and polishing – complete dentition, periodontally compromised patient)	8727 (provisional splinting – extracoronal, per quadrant)
8737 (root planing – four (4) or more teeth per quadrant)	8746 (flap operation with root planing and curettage (open curettage) – four (4) or more teeth per quadrant)
8739 (root planing – one (1) to three (3) teeth per quadrant)	8747 (flap operation with root planing and curettage, including bone surgery – one (1) to three (3) teeth per quadrant)
	8748 (flap operation with root planing and curettage, including bone surgery – four (4) or more teeth per quadrant)
	8749 (flap procedure, root planing and one (1) to three (3) surgical services per quadrant)

NOTE: The 'Dental report' form is available at **www.gems.gov.za.** Email the completed form and supporting documentation to enquiries@gems.gov.za or fax to **0861 00 4367.**

Tanzanite One and Beryl – Specific Rules that apply to CBCT scans

Cone Beam Computed Tomography (CBCT) scans are limited to one (1) per beneficiary per lifetime for surgical procedures subject to the provider being registered for CBCT with the Scheme. Subject to Scheme Rules and managed care protocols.

The following table details the reimbursement codes for CBCT scans as well as the discipline restrictions per code:

Code	Procedure Description	Practice Disciplines: Tanzanite One & Beryl*
8194	CBCT capture and interpretation with limited field of view – less than one (1) whole jaw.	Not allowed for 64, 92, 94, 95 & 113 disciplines
8195	CBCT capture and interpretation with limited field of view of one (1) full dental arch – mandible.	Not allowed for 64, 92, 94, 95 & 113 disciplines
8196	CBCT capture and interpretation with limited field of view of one (1) full dental arch – maxilla without orbits and/or cranium.	Not allowed for 64, 92, 94, 95 & 113 disciplines
8197	CBCT capture and interpretation with limited field of view of both dental arches – without orbits and or cranium.	Not allowed for 64, 92, 94, 95 & 113 disciplines
8198	CBCT capture and interpretation for TMJ series including two (2) or more exposures.	Not allowed for 64, 92, 94, 95 & 113 disciplines
8199	CBCT capture and interpretation with limited field of view of one (1) full dental arch – maxilla with orbits and/or cranium.	Only for 62 disciplines
8200	CBCT capture and interpretation with field of view of both dental arches – with orbits and/or cranium.	Only for 62 disciplines
8217	CBCT capture and interpretation for the visualisation of sinuses.	Not allowed for 64, 92, 94, 95 & 113 disciplines

***Key to discipline types:** 54 – general dental practitioner (GP) | 62 – specialist maxillo-facial and oral surgeon (MS)) | 64 – specialist orthodontist (OR) 92 – specialist in oral medicine and periodontics (OMP)) | 94 – specialist prosthodontist (PR)) | 95 – dental therapist (DT)) | 113 – oral hygienist (OH)

The following table details the CBCT tariff codes that are not funded by the Scheme:

Codes Not Funded	Procedure Description
8193	Three-dimensional reconstruction of cone beam volumetric image using existing data (includes multiple images).
8203	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including the report.
8205	CBCT image capture with limited field of view – less than one (1) whole jaw.
8206	CBCT image capture with limited field of view of one (1) full dental arch – mandible.
8207	CBCT image capture with limited field of view of one (1) full dental arch – maxilla without orbits and or cranium.
8208	CBCT image capture with limited field of view of one (1) full dental arch – maxilla with orbits and/or cranium.
8209	CBCT capture for TMJ series including two (2) or more exposures.
8210	CBCT image capture with limited field of view of one (1) full dental arch – maxilla with orbits and/or cranium.
8211	CBCT capture with field of view of both dental arches – with orbits and/or cranium.

Tanzanite One and Beryl - Approved Service codes and table of benefits

Code	Code Description	Limitations	COVERED: Tanzanite One	COVERED: Beryl
Diagnostic dental services and preventative treatment				
8101	Consultation / oral examination	Two (2) per beneficiary per year; i.e. one (1) every six (6) months.	Yes	Yes
8104	Limited oral examination: Examination for a specific problem not requiring full mouth examination.	Two (2) per beneficiary per year.	Yes	Yes
8107	Intraoral radiographs – periapical, per film	Maximum of six (6) per beneficiary per year.	Yes	Yes
8112	Intraoral radiographs – bitewings	Maximum of four (4) per beneficiary per year.	Yes	Yes
8115	Extraoral radiographs – panoramic X-ray	Benefit from the age of six (6) – maximum one (1) every three (3) years.	Yes	Yes
8155	Polishing – complete dentition	Two (2) per beneficiary per 12 months; i.e. one (1) every six (6) months; cannot be charged with 8159 in same year.	Yes	Yes
8159	Prophylaxis – complete dentition (scaling and polishing)	Two (2) per beneficiary per 12 months; i.e. one (1) every six (6) months; only over the age of 10.	Yes	Yes
8161	Topical application of fluoride (children)	From the age of three (3) to the age of 11; once per beneficiary per 12 months.	Yes	Yes
8162	Topical application of fluoride (adults)	From the age of 12 to the age of 16; once per beneficiary per 12 months.	Yes	Yes
8163	Dental sealant, per tooth	Patient younger than 14; maximum of two (2) dental fissure sealants per quadrant on posterior permanent teeth only. Subject to relevant managed care protocols.	Yes	Yes
Restorations				
8341	Amalgam – one (1) surface	Any four (4) amalgam fillings per beneficiary per year; limited to four (4) restorations overall, and once per tooth in 720 days.	Yes	Yes; pre-authorisation needed for more than four (4) fillings.
8342	Amalgam – two (2) surfaces		Yes	
8343	Amalgam – three (3) surfaces		Yes	
8344	Amalgam – four (4) and more surfaces		Yes	

Code	Code Description	Limitations	COVERED: Tanzanite One	COVERED: Beryl
Restorations				
8351	Resin restoration – one (1) surface, anterior	Any four (4) resin fillings per beneficiary per year (anterior); limited to four (4) restorations overall, and once per tooth in 720 days.	Yes	Yes; pre-authorisation needed for more than four (4) fillings.
8352	Resin restoration – two (2) surfaces, anterior		Yes	
8353	Resin restoration – three (3) surfaces, anterior		Yes	
8354	Resin restoration – four (4) and more surfaces, anterior		Yes	
8367	Resin restoration – one (1) surface, posterior	Any four (4) resin fillings per beneficiary per year (posterior); limited to four (4) restorations overall, and once per tooth in 720 days.	Yes	Yes; pre-authorisation needed for more than four (4) fillings.
8368	Resin restoration – two (2) surfaces, posterior			
8369	Resin restoration – three (3) surfaces, posterior			
8370	Resin restoration – four (4) and more surfaces, posterior			
Extractions and surgical extractions – GEMS dental network provider				
8201	Extraction of tooth	Any four (4) non-surgical extractions per beneficiary per year; only if clinically indicated.	Yes	Yes
8937	Surgical removal of erupted tooth – report per tooth	Maximum of two (2) removals.	Yes, from the age of 12.	Yes, from the age of 12.
8213	Surgical removal of residual tooth roots	Maximum of two (2) procedure – more than one (1) requires clinical motivation.	Yes, from the age of 12	Yes, from the age of 12.
8220	Sutures	In association with surgical extractions and/or impactions; limited to once per year per beneficiary, subject to motivation.	Yes	Yes
8935	Treatment of septic socket	One (1) per beneficiary per 12 months, subject to managed care protocols.	Yes	Yes
8109	Infection control/barrier techniques. Code 8109 includes provision by a dental practitioner of new rubber gloves, masks etc. for each patient.	Two (2) per visit.	Yes	Yes
8110	Sterilised instrumentation	One (1) per visit.	Yes	Yes
8145	Local anaesthetic	One (1) per visit.	Yes	Yes
Extractions and surgical extractions – non-network provider (as part of emergency visit)				
8201	Extraction of tooth or exposed tooth roots	Any four (4) non-surgical extractions per beneficiary per year; only if clinically indicated. Only funded as part of one (1) emergency out-of-network visit per beneficiary per year.	Yes	Yes

Code	Code Description	Limitations	COVERED: Tanzanite One	COVERED: Beryl
8109	Infection control/barrier techniques Code 8109 includes provision by a dental practitioner of new rubber gloves, masks etc. for each patient.	Two (2) per visit. Only funded as part of one (1) emergency out-of-network visit per beneficiary per year.	Yes	Yes
8110	Sterilised instrumentation	One (1) per visit. Only funded as part of one (1) emergency out-of-network visit per beneficiary per year.	Yes	Yes
8145	Local anaesthetic	One (1) per visit. Only funded as part of one (1) emergency out-of-network visit per beneficiary per year.	Yes	Yes
Dentures				
8231	Complete dentures – maxillary and mandibular	One (1) set of plastic dentures allowed per beneficiary per 48 months. Pre-authorisation necessary Only members and beneficiaries over the age of 21.	Yes	Yes
8232	Complete dentures – maxillary or mandibular		Yes	Yes
8233	Partial denture – one (1) tooth		Yes	Yes
8234	Partial denture – two (2) teeth		Yes	Yes
8235	Partial denture – three (3) teeth		Yes	Yes
8236	Partial denture – four (4) teeth		Yes	Yes
8237	Partial denture – five (5) teeth		Yes	Yes
8238	Partial denture – six (6) teeth		Yes	Yes
8239	Partial denture – seven (7) teeth		Yes	Yes
8240	Partial denture – eight (8) teeth		Yes	Yes
8241	Partial denture – nine (9) teeth and more		Yes	Yes
8259	Rebase complete or partial dentures (lab)	Rebase only allowed once every two (2) years.	Yes	Yes
8269	Repair denture	Cannot be completed within six (6) months of fitting a new denture.	Yes	Yes
8263	Reline complete or partial dentures (chair side)	Reline only allowed once every two (2) years.	Yes	Yes
8271	Add tooth to existing partial dentures	Cannot be completed within six (6) months of fitting a new denture.	Yes	Yes
8273	Impression to repair or modify a denture, or other removable intraoral appliance	Cannot be completed within six (6) months of fitting a new denture.	Yes	Yes
Root canal treatment				
8307	Pulp amputation (pulpotomy)	Pulpotomy only on primary teeth.	Yes	Yes

Code	Code Description	Limitations	COVERED: Tanzanite One	COVERED: Beryl
8132	Pulp removal (pulpectomy)	Once per beneficiary per 12 months; one (1) event per beneficiary per benefit year allowed for emergency dentistry.	Yes	Yes
8303	Pulp cap – indirect	Limited to once per tooth per lifetime and one (1) complete root canal therapy event (one tooth only) per beneficiary per 12 months.	Yes	Yes
8317	Root canal preparation, each additional canal	Limited to five (5) per tooth per lifetime and one (1) complete root canal therapy event (one tooth only) per beneficiary per 12 months.	Yes	Yes
8318	Irrigation and medication per tooth at a separate visit	Limited to once per tooth per lifetime and one (1) complete root canal therapy event (one tooth only) per beneficiary per 12 months.	Yes	Yes
8328	Root canal obturation – anteriors and premolars, each additional canal	Limited to two (2) per tooth per lifetime and one (1) complete root canal therapy event (one tooth only) per beneficiary per 12 months.	Yes	Yes
8329	Root canal therapy – anteriors and premolars, each additional canal	Limited to two (2) per tooth per lifetime and one (1) complete root canal therapy event (one tooth only) per beneficiary per 12 months.	Yes	Yes
8330	Removal of root canal obstruction	Limited to once per tooth per lifetime and one (1) complete root canal therapy event (one tooth only) per beneficiary per 12 months.	Yes	Yes
8331	Repair of perforation defects	Limited to once per tooth per lifetime and one (1) complete root canal therapy event (one tooth only) per beneficiary per 12 months.	Yes	Yes
8332	Root canal preparatory visit – single canal tooth	Limited to once per tooth per lifetime and one (1) complete root canal therapy event (one tooth only) per beneficiary per 12 months.	Yes	Yes
8333	Root canal preparatory visit – multi canal tooth	Limited to once per tooth per lifetime and one (1) complete root canal therapy event (one tooth only) per beneficiary per 12 months.	Yes	Yes
8335	Root canal obturation – anteriors and premolars, first canal	Limited to once per tooth per lifetime and one (1) complete root canal therapy event (one tooth only) per beneficiary per 12 months.	Yes	Yes

Code	Code Description	Limitations	COVERED: Tanzanite One	COVERED: Beryl
8336	Root canal obturation – posteriors, first canal	Limited to once per tooth per lifetime and one (1) complete root canal therapy event (one tooth only) per beneficiary per 12 months.	Yes	Yes
8337	Root canal obturation – posteriors, each additional canal	Limited to four (4) per tooth per lifetime and one (1) complete root canal therapy event (one tooth only) per beneficiary per 12 months.	Yes	Yes
8338	Root canal therapy – anteriors and premolars, first canal	Limited to once per tooth per lifetime and one (1) complete root canal therapy event (one tooth only) per beneficiary per 12 months.	Yes	Yes
8339	Root canal therapy – posteriors, first canal	Limited to once per tooth per lifetime and one (1) complete root canal therapy event (one tooth only) per beneficiary per 12 months.	Yes	Yes
8340	Root canal therapy – posteriors, each additional canal	Limited to four (4) per tooth per lifetime and one (1) complete root canal therapy event (one tooth only) per beneficiary per 12 months.	Yes	Yes
8640	Removal of fractured root canal instrument	Limited to once per tooth per lifetime and one (1) complete root canal therapy event (one tooth only) per beneficiary per 12 months.	Yes	Yes
Periodontal treatment				
8176	Periodontal examination (screening)	One (1) per beneficiary per six (6) months.	Yes	Yes
8179	Polishing – complete dentition (periodontally compromised patient)	Subject to pre-authorisation and registration on the Periodontal Programme.	Yes	Yes
8180	Scaling and polishing – complete dentition (periodontally compromised patient)	Subject to pre-authorisation and registration on the Periodontal Programme.	Yes	Yes
8737	Root planing – four (4) or more teeth per quadrant	Subject to pre-authorisation and registration on the Periodontal Programme Only one (1) of the following code combinations is allowed per beneficiary per year: 8737 x4 8739 x4 8737 x1 and 8739 x3 8737 x2 and 8739 x2 8737 x3 and 8739 x1	Yes	Yes
8739	Root planing – one (1) to three (3) teeth per quadrant		Yes	Yes

Ruby, Emerald Value, Emerald and Onyx: General administration, benefits and procedures covered

Ruby, Emerald Value, Emerald and Onyx - Shared Dental Sublimit

Ruby	Emerald Value and Emerald	Onyx
Shared dental sublimit of R4 292 per beneficiary per year for in-hospital dentistry professional fees and all out-of-hospital dentistry.	Shared dental sublimit of R6 597 per beneficiary per year for in-hospital dentistry professional fees and all out-of-hospital dentistry.	Shared dental sublimit of R11 769 per beneficiary per year for in-hospital dentistry professional fees and all out-of-hospital dentistry.

Ruby, Emerald Value, Emerald and Onyx - Summarised Benefits Covered

Benefits Specifications	Ruby	Emerald Value and Emerald	Onyx
Provider limitations	Services not limited to GEMS Dental Network providers.		
Conservative and restorative dentistry (including plastic dentures)	100% of Scheme rate subject to available funds.		
Preventative care services benefit for dental fissure sealants	• Dental fissure sealants are funded from the Preventative Care Services benefit on the Ruby, Emerald Value, Emerald and Onyx options and not from the shared dental sublimit. • This benefit enhancement is applicable to beneficiaries younger than 18 years of age who make use of network service providers only. • Should beneficiaries receive this treatment from a non-network service provider, the treatment will be paid from the shared dental sublimit and not the Preventative Care Services benefit. • The benefit for dental fissure sealants is available to a maximum of two (2) per quadrant and once every two (2) years per tooth.		
Preventative care services benefit for dental polishing	• Dental polishing (code 8155) are funded from the Preventative Care Services benefit on the Ruby, Emerald Value, Emerald and Onyx options and not from the shared dental sublimit. • This benefit enhancement is applicable to beneficiaries from the age of three (3) to nine (9) years (both inclusive). • Code 8155 for all other covered beneficiaries payable from the available shared dental sublimit.		

Benefits Specifications	Ruby	Emerald Value and Emerald	Onyx
Specialised dentistry (including metal base partial dentures).	• No pre-authorisation required for partial metal base dentures. • Pre-authorisation required for all other specialised dentistry procedures. • Implant supported crowns, bridges, and dentures, subject to pre-authorisation. • First and second phases of implant procedures, and orthognathic surgery are a Scheme exclusion. Excludes orthodontic treatment on patients older than 21.		
Surgical procedures: Maxillofacial surgery, and surgical removal of impacted teeth under general anaesthesia or conscious sedation in the rooms.	• Subject to pre-authorisation, managed care protocols and processes. • 100% of Scheme Rate, not subject to shared dental sublimit. • 200% of Scheme Rate for surgical removal of impacted teeth if authorised under conscious sedation in the rooms, not subject to shared dental sublimit.		
General anaesthesia	• General anaesthesia only applicable to Beneficiaries: - up to and including the age of six (6) years - removal of impacted teeth - with severe trauma • Subject to Scheme rules, relevant managed care protocols and pre-authorisation. • Professional fees, subject to shared dental sublimit.		
Conscious sedation in the rooms for conservative and restorative dentistry.	• Conscious sedation in rooms: - Only applicable to Beneficiaries up to and including the age of nine (9) years; subject to pre-authorisation and managed care protocols and processes. • Professional fees, subject to shared dental sublimit. • Anaesthetists are required to obtain a separate authorisation for dental-related conscious sedation procedures.		

CHARTING: As part of code 8101, a once-off patient charting and oral examination will be required for each beneficiary visiting your practice for the first time. The charting is to be submitted to the Scheme on the 'Dental report' form.

Please ensure that pre-authorisations are obtained before starting treatment where indicated, i.e. specialised dentistry, orthodontic treatment, in-hospital (theatre) and conscious sedation-associated treatment.

Ruby, Emerald Value, Emerald and Onyx – General Rules

General principles

- All dental procedures are covered by the rules applicable per specific Scheme option.
- All specialised dentistry and in-hospital dentistry are subject to pre-authorisation before start of treatment.
- Hospital authorisation for admission to a private facility must be obtained from the Scheme at least 48 hours before a beneficiary is admitted to a private facility (except in the event of an Emergency Medical Condition), failing which, a co-payment of R1 000 per admission shall apply.
- In the event of an admission to a private facility for an Emergency Medical Condition, the Scheme must be notified of such admission within one (1) working day after the admission, failing which, a co-payment of R1 000 per admission shall apply.
- An authorisation granted is not a guarantee of payment – payment remains strictly subject to availability of funds and an active and valid membership at the time of service.
- Confirmation of benefits is not a guarantee of payment – payment remains strictly subject to availability of funds.
- Hospital authorisations are valid for one (1) month, and all other authorisations are valid for three (3) months.
- Where the dental treatment plan changes, authorisations must be updated before submitting the claim.

Orthodontic treatment

- Benefits applicable only to beneficiaries under 21.
- Authorisation and a treatment plan apply, and benefits subject to prior evaluation according to the Index of Complexity, Outcome and Treatment Need (ICON) criteria.
- Once approved, an initial amount will be payable and the balance in increments subject to availability of funds. Valid claims will only be covered if the beneficiary's GEMS membership is active during the treatment period.
- 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.
- In the instance that a member changes options whilst on treatment, the provider must please discuss the cost difference with the member as the provider will have confirmed benefits for the member for continued service. In options where there is no cover or reduced benefit for orthodontics, the provider will need to inform member of the shortfall they would be liable for.
- Should a case be transferred to another provider, only the balance due as per original treatment plan is covered.
- When treating beneficiaries who transferred from another provider, e.g. the member relocated or is seeking a second opinion, kindly request the member to obtain records from the applicable provider to avoid possible overexposure to radiation from repeated radiographs.
- Orthodontic exclusions: Refer to "General exclusions and restrictions".

Hospitalisation

- General anaesthesia applicable to beneficiaries up to and including the age of six (6) years only:
  - Considered only where no other options are available.
  - All procedures necessary to be completed in one (1) theatre-associated event.
  - Only necessary restorative and surgical (e.g. extractions) procedures may be performed. No preventative treatment (polish, fluoride treatment, dental fissure sealants) will be covered in theatre.
- Treatment under general anaesthesia covered for surgical removal of impacted teeth or treatment of severe trauma as per Scheme rules.
- No other procedures apply.
- Subject to pre-authorisation.
- Emerald Value option: A co-payment of up to R15 000 may be levied should you not use a GEMS network hospital.

Ruby, Emerald Value, Emerald and Onyx – Specific Rules that apply to CBCT scans

Cone Beam Computed Tomography (CBCT) scans are limited to one (1) per beneficiary per lifetime for surgical procedures subject to the provider being registered for CBCT. Subject to Scheme Rules, and managed care protocols.

The following table details the reimbursement codes for CBCT scans as well as the discipline restrictions per code:

Code	Procedure Description	Practice Disciplines*
8194	CBCT capture and interpretation with limited field of view – less than one (1) whole jaw.	Not allowed for 95 & 113 disciplines
8195	CBCT capture and interpretation with limited field of view of one (1) full dental arch – mandible.	Not allowed for 95 & 113 disciplines
8196	CBCT capture and interpretation with limited field of view of one (1) full dental arch – maxilla without orbits and/or cranium.	Not allowed for 95 & 113 disciplines
8197	CBCT capture and interpretation with limited field of view of both dental arches – without orbits and or cranium.	Not allowed for 95 & 113 disciplines
8198	CBCT capture and interpretation for TMJ series including two (2) or more exposures.	Not allowed for 95 & 113 disciplines
8199	CBCT capture and interpretation with limited field of view of one (1) full dental arch – maxilla with orbits and/or cranium.	Only for 62 & 94 disciplines
8200	CBCT capture and interpretation with field of view of both dental arches – with orbits and/or cranium.	Only for 62 & 94 disciplines
8217	CBCT capture and interpretation for the visualisation of sinuses.	Not allowed for 95 & 113 disciplines

***Key to discipline types:** 54 – general dental practitioner (GP) | 62 – specialist maxillo-facial and oral surgeon (MS) | 64 – specialist orthodontist (OR) 92 – specialist in oral medicine and periodontics (OMP) | 94 – specialist prosthodontist (PR) | 95 – dental therapist (DT) | 113 – oral hygienist (OH)

The following table details the CBCT tariff codes that are not funded by the Scheme:

Codes Not Funded	Procedure Description
8193	Three-dimensional reconstruction of cone beam volumetric image using existing data (includes multiple images).
8203	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including the report.
8205	CBCT image capture with limited field of view – less than one (1) whole jaw.
8206	CBCT image capture with limited field of view of one (1) full dental arch – mandible.
8207	CBCT image capture with limited field of view of one (1) full dental arch – maxilla without orbits and or cranium.
8208	CBCT image capture with limited field of view of one (1) full dental arch – maxilla with orbits and/or cranium.
8209	CBCT capture for TMJ series including two (2) or more exposures.
8210	CBCT image capture with limited field of view of one (1) full dental arch – maxilla with orbits and/or cranium.
8211	CBCT capture with field of view of both dental arches – with orbits and/or cranium.

Ruby, Emerald Value, Emerald and Onyx – Specific Rules that apply to dental implants

Although all implant related clinical and laboratory associated procedures remain excluded (for Phase 1 and Phase 2 implant procedures), benefits will be available from the shared dental sublimit for Phase 3 implant supported crowns, bridges, and dentures subject to pre-authorisation and managed care protocols.

The following implant denture codes require pre-authorisation:

PHASE 3 Implant Codes Funded
8533 (Implant supported removable complete overdenture)
8534 (Implant supported removable partial overdenture)
8654 (Implant supported fixed-detachable complete overdenture)
8655 (Implant supported fixed-detachable partial overdenture)
8660 (Additional fee to implant supported fixed-detachable denture – per implant)

Table of Benefits: Ruby, Emerald Value, Emerald and Onyx

Conservative Dentistry	Ruby	Emerald Value and Emerald	Onyx
Dental consultation yearly check-up	Two (2) annual consultations per beneficiary, one (1) every six (6) months.	Two (2) annual consultations per beneficiary, one (1) every six (6) months.	Two (2) annual consultations per beneficiary, one (1) every six (6) months.
Diagnostics	8107 (Intraoral radiograph – periapical): Diagnosis and treatment procedures where necessary, limited to 10 per beneficiary per 12 months.	8107 (Intraoral radiograph-periapical): Diagnosis and treatment procedures where necessary, limited to 10 per beneficiary per 12 months.	8107 (Intraoral radiograph-periapical): Diagnosis and treatment procedures where necessary, limited to 10 per beneficiary per 12 months.
	8108 (Intraoral radiograph – complete series): Benefit from the age of six (6) – one (1) every 24 months.	8108 (Intraoral radiograph – complete series): Benefit from the age of six (6) – one (1) every 24 months.	8108 (Intraoral radiograph – complete series): Benefit from the age of six (6) – one (1) every 24 months.
	8112 (Intraoral radiograph – bitewing): Maximum of six (6) per 12 months.	8112 (Intraoral radiograph – bitewing): Maximum of six (6) per 12 months.	8112 (Intraoral radiograph – bitewing): Maximum of six (6) per 12 months.
	8115 (Extraoral radiograph – panoramic): Benefit from the age of six (6) – maximum one (1) every 36 months.	8115 (Extraoral radiograph – panoramic): Benefit from the age of six (6) – maximum one (1) every 36 months.	8115 (Extraoral radiograph – panoramic): Benefit from the age of six (6) – maximum one (1) every 36 months.
	8116 (Cephalometric radiograph), 8114 (Extraoral radiograph): For orthodontic treatment only.	8116 (Cephalometric radiograph), 8114 (Extraoral radiograph): For orthodontic treatment only.	8116 (Cephalometric radiograph), 8114 (Extraoral radiograph): For orthodontic treatment only.

Conservative Dentistry	Ruby	Emerald Value and Emerald	Onyx
Infection control	8109 (Infection control/ barrier techniques): Twice per visit	8109 (Infection control/ barrier techniques): Twice per visit	8109 (Infection control/ barrier techniques): Twice per visit
	8110 (Sterilised instrumentation): Once per visit	8110 (Sterilised instrumentation): Once per visit	8110 (Sterilised instrumentation): Once per visit
Preventative dentistry	8163 (Dental sealant – per tooth): • Maximum of two (2) dental fissure sealants per quadrant and once every two (2) years per tooth – no benefit for beneficiaries over the age of 18 years • Funded from the Preventative Care Services benefit if treatment received from a GEMS Dental Network Provider	8163 (Dental sealant – per tooth): • Maximum of two (2) dental fissure sealants per quadrant and once every two (2) years per tooth – no benefit for beneficiaries over the age of 18 years • Funded from the Preventative Care Services benefit if treatment received from a GEMS Dental Network Provider	8163 (Dental sealant – per tooth): • Maximum of two (2) dental fissure sealants per quadrant and once every two (2) years per tooth – no benefit for beneficiaries over the age of 18 years • Funded from the Preventative Care Services benefit if treatment received from a GEMS Dental Network Provider
	8159 (Scaling and polishing): Once every six (6) months – from the age of 10 only	8159 (Scaling and polishing): Once every six (6) months – from the age of 10 only	8159 (Scaling and polishing): Once every six (6) months – from the age of 10 only
	8155 (Polishing): Once every six (6) months	8155 (Polishing): Once every six (6) months	8155 (Polishing): Once every six (6) months
	8161 (Topical application of fluoride – child): From the age of three (3) to the age of 11, once every six (6) months	8161 (Topical application of fluoride – child): From the age of three (3) to the age of 11, once every six (6) months	8161 (Topical application of fluoride – child): From the age of three (3) to the age of 11, once every six (6) months
	8162 (Topical application of fluoride – adult): From the age of 12 to the age of 16, once every six (6) months	8162 (Topical application of fluoride – adult): From the age of 12 to the age of 16, once every six (6) months	8162 (Topical application of fluoride – adult): From the age of 12 to the age of 16, once every six (6) months
Restorations/ fillings	Benefits available where clinically indicated – once per tooth in 720 days	Benefits available where clinically indicated – once per tooth in 720 days	Benefits available where clinically indicated – once per tooth in 720 days
Dentures	One (1) set of full, or full upper or full lower, or partial upper and/or partial lower plastic dentures once every four (4) years; relines, rebase, soft base every two (2) years; metal framework every five (5) years	One (1) set of full, or full upper or full lower, or partial upper and/or partial lower plastic dentures once every four (4) years; relines, rebase, soft base every two (2) years; metal framework every five (5) years	One (1) set of full, or full upper or full lower, or partial upper and/or partial lower plastic dentures once every four (4) years; relines, rebase, soft base every two (2) years; metal framework every five (5) years
Endodontic (root canal) treatment	8132 (Pulp removal – pulpectomy) not allowed on same day as root treatment	8132 (Pulp removal – pulpectomy) not allowed on same day as root treatment	8132 (Pulp removal – pulpectomy) not allowed on same day as root treatment

Specialised Dentistry	Ruby	Emerald Value and Emerald	Onyx
Crowns and bridges	Pre-authorisation necessary; benefit available once per tooth per five (5) years	Pre-authorisation necessary; benefit available once per tooth per five (5) years	Pre-authorisation necessary; benefit available once per tooth per five (5) years
Implant supported crowns and crown retainers	Benefit available for Phase 3 implant crowns, bridges and dentures, subject to pre-authorisations and available shared dental sublimit	Benefit available for Phase 3 implant crowns, bridges and dentures, subject to pre-authorisations and available shared dental sublimit	Benefit available for Phase 3 implant crowns, bridges and dentures, subject to pre-authorisations and available shared dental sublimit
Orthodontics	Treatment plan necessary; benefit limited to patients under 21 years	Treatment plan necessary; benefit limited to patients under 21 years	Treatment plan necessary; benefit limited to patients under 21 years
Periodontics	Treatment plan necessary	Treatment plan necessary	Treatment plan necessary
Maxillo-facial & oral/dental surgery	Pre-authorisation necessary when done in theatre or under conscious sedation; impacted wisdom teeth paid at 200% of rate when performed under conscious sedation in dentist's rooms	Pre-authorisation necessary when done in theatre or under conscious sedation; impacted wisdom teeth paid at 200% of rate when performed under conscious sedation in dentist's rooms	Pre-authorisation necessary when done in theatre or under conscious sedation; impacted wisdom teeth paid at 200% of rate when performed under conscious sedation in dentist's rooms

Dental Hospitalisation	Ruby	Emerald Value and Emerald	Onyx
Dental hospitalisation*	For patients under the age of six (6), bony impactions, and severe trauma (PMB). Subject to pre-authorisation, treatment protocols and PMB conditions	For patients under the age of six (6), bony impactions, and severe trauma (PMB). Subject to pre-authorisation, treatment protocols and PMB conditions	For patients under the age of six (6), bony impactions, and severe trauma (PMB). Subject to pre-authorisation, treatment protocols and PMB conditions

***Emerald Value:** Non-network hospital use may attract a co-payment of up to R15 000.

All GEMS options:
General exclusions and restrictions (excludes PMB)

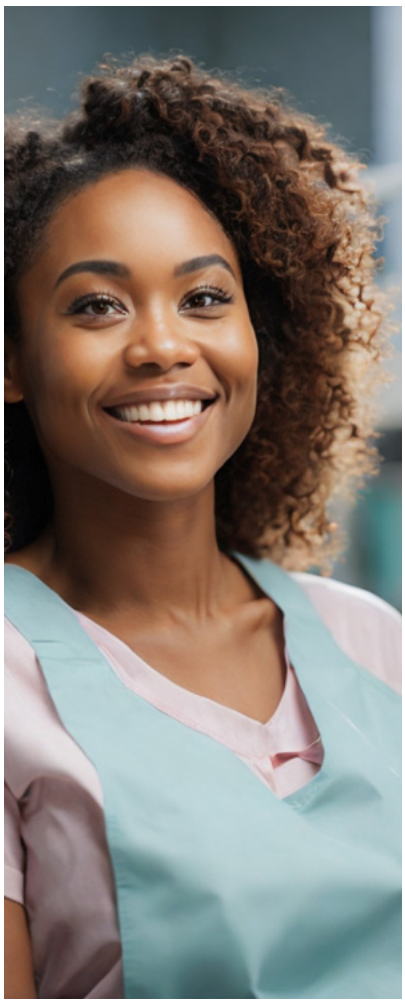
Exclusions

Please refer to the summary of benefits, detailed procedure benefit lists/schedules, and general exclusions detailed earlier in this guide pertaining to each Scheme option to ensure compliance with the benefits allowed, exclusions and managed care rules (e.g. pre-authorisation, number of annual events, age rules etc.).

Where treatment is performed where an exclusion exists, or the patient's benefits have been exceeded, the patient will have to self-fund – please ensure the "Patient consent" form for limits exceeded is completed by the patient and kept on file at the practice.

Diagnostic / Preventative Treatment

- Special report
- Dental testimony
- Appointment not kept
- Nutritional counselling
- Tobacco counselling
- Oral hygiene instruction and/or associated visits
- Behaviour management
- Cost of toothbrushes, toothpastes and mouthwashes
- Microbiological studies
- Caries susceptibility tests
- Diagnostic models covered only in association with orthodontic treatment
- Oral and/or facial image (digital and conventional) covered only where orthodontic treatment applies
- Removal of gross calculus
- Dental fissure sealants in patients older than 18 or where teeth have been in the mouth for more than four (4) years
- Fluoride treatment for patients older than 16



Fillings and Restorations

- Resin bonding for restorations charged separately from the restoration
- Enamel micro-abrasion
- Elective replacement of fillings
- Gold or gold foil restorations

Dentures

- Diagnostic dentures
- Snoring apparatus
- Clasp or rest – cast gold
- Clasp or rest – wrought gold
- Inlay in denture
- Metal base to full dentures
- Metal frames for partial dentures limited to one (1) per jaw and once every five (5) years.

Crown and Bridge

- Where an underlying periodontal condition (e.g. extensive loss of alveolar bone) compromises an acceptable term prognosis
- Where a lack of remaining tooth structure compromises an acceptable prognosis
- Where enough remaining tooth structure does not justify a crown as the restoration of choice
- On a failed root canal-treated tooth
- For cosmetic reasons
- Allowed once per tooth every five (5) years
- Emergency crowns not placed for immediate protection of injured teeth
- Temporary and provisional crowns, including laboratory costs
- Pontics on second molars
- On primary teeth or third molars
- Cost of gold, semi-precious metal and platinum foil
- 8570 – computer generated restoration: Laboratory not allowed with this code (only 8560)

Implants

All implant related clinical and laboratory associated procedures (including the implant placement, cost of components, and restorations/repairs associated with implants for Phase 1 and Phase 2) are excluded.

The exclusion does not apply to Phase 3 implant supported crowns/bridges/dentures subject to pre-authorisation.

Endodontic Treatment

- On third molars
- On primary teeth
- Emergency root canal treatment charged on the same day as the completed root canal treatment
- Retreatment not covered within two (2) years of initial treatment
- Motivation required for treatment under the age of 14

Orthodontic treatment exclusions

- Retreatment of orthodontic treatment
- Lost appliances not covered
- Lingual orthodontics not covered
- Ceramic brackets not covered
- Refixing of orthodontic brackets not covered
- Retainers limited to one (1) per jaw
- Treatment planning for orthognathic surgery

In-Hospital (Theatre)

- For patients under the age of six (6), bony impactions and severe trauma as per Scheme rules – no other procedures apply
- Preventative dental procedures as part of the dental treatment performed on children under the covered

Inlays and Onlays

- Exclude tooth numbers one (1) to three (3) in all quadrants
- No benefit for gold or precious metal
- Allowed once every four (4) years

Other

- Cosmetic dentistry
- The treatment of any complication related to treatment not funded by the Scheme
- Intramuscular and subcutaneous injections
- All procedures related to bleaching (except internal bleaching on previously endodontically treated teeth)
- PerioChip replacement
- Treatment plan completed (code 8120)
- Cost of mineral trioxide
- Ozone therapy
- Cost of gold, semi-precious metal and platinum foil
- Orthognathic surgery and related hospital costs
- Occlusal adjustment minor (pre-authorisation necessary for major occlusal adjustment)
- Bone regeneration procedures
- Cost of bone regenerative/repair material
- Any laboratory costs where the associated procedure is not covered
- Dental MRI or CAT scans not covered

Dental medicine formulary

The GEMS dental medicine formulary is available at **www.gems.gov.za.**

Medicine may be prescribed:

- According to the GEMS dental medicine formulary
- By a dentist or dental therapist (within his/her scope)

For Tanzanite One and Beryl options, medicine must be dispensed by approved courier pharmacies GEMS network courier pharmacies or dispensing dentists.

Key to quantities and limitations

"Consumables" means the medication may be administrated only by a designated service provider (DSP) at the rooms. All injectables are consumables, and claims for scripts given to patients to collect from DSP pharmacies will be rejected.

"Max Rx/7 days & 3 Rx/annum" means a script filled up to a maximum of seven (7) days' medicine supply and three (3) prescriptions per year may be claimed.

Benefits for medicine are subject to reference pricing lists (MPLs) and exclusion lists (MELs). Should the cost of the item exceed MPL, the patient will be liable for payment of the difference in cost. If this is the case, please inform the patient that it is for his/her own personal account.

Dental therapists may prescribe as per the latest government gazette published by the Department of Health.

Note: Provider trade names are not listed on formulary, allowing for generic substitution, but applying MPLs and MELs.

Disclaimer: The formulary is reviewed regularly by clinical and pharmaceutical advisors to ensure that it complies with the latest industry norms for the treatment of these conditions. GEMS reserves the right to change medicines on the formulary when important information comes to light that requires it, e.g. new finding regarding the safety of a drug.

Pre-authorisation

In all cases where pre-authorisation is required, as specified earlier and per option in this guide, please complete the relevant sections of the ”Dental report” form for registration, pre-notification and pre-authorisation and submit to the Scheme before starting treatment.

Should you be unsure whether pre-authorisation is required, contact the call centre on 0860 436 777 to prevent rejection of the patient’s account by the Scheme.

Orthodontic treatment:

Before treatment, submit to the Scheme for approval a “Dental report” form for pre-authorisation as well as a treatment plan, which should include the diagnosis and payment quotation.
Send an email to **enquiries@ gems.gov.za** or fax to **0861 00 4367**.

Periodontal treatment:

Complete and submit the “Periodontal” form, downloadable from **www.gems.gov.za.**

Note: Tooth charting on the form is not necessary for pre-authorisation or treatment plan (charting needs to be completed only at the patient’s first visit to the practice in terms of code 8101).

Claim procedures

Required information on claims

- Main member details such as membership number, option, name and contact details
- Patient details, including date of birth, name and identity number
- Provider details, including a valid Board of Healthcare Funders practice number, name and contact
- details
- Diagnosis and summary of medical procedures performed, medicine dispensed, other items dispensed to patient including NAPPI codes and quantity.
- Relevant tariff codes and ICD-10 code
- Complete list of individual laboratory codes
- Associated costs

Rejection of claims

- If the details are incomplete the claim will be rejected.
- The clinical and laboratory codes are to be submitted together, reflecting corresponding service dates, corresponding details of codes used and authorisation numbers for laboratory codes where clinical codes require pre-authorisation.
- Self-claiming laboratories may not submit their claim without confirmation with the dental provider that the clinical delivery was completed.
- Any other procedures done outside the scope of benefit will not be paid.
- All claims from non-network dental providers on Tanzanite One and Beryl options, except emergency consultations (limited to one (1) event per year), will not be funded.
- All claims requiring pre-authorisation – if no valid pre-authorisation exists, the claim will be rejected.

Member **verification and validation**

Verification on benefits

- Always ensure that available benefit codes and tariff values are verified with the Scheme.
- The dental provider is required to verify membership details and confirm the identity of the patient.
- The Scheme will not be held responsible for payment of services excluded by it or managed care
- rules.
- Members will be liable for claims incurred on benefits falling outside the benefit schedule.
- Benefit confirmation via pre-authorisation is required where indicated.

Non-disclosure and Underwriting

Underwriting

Underwriting is a risk management tool that medical funders implement as per the Medical Schemes Act. Underwriting is the assessment of a new member or beneficiary's risk profile 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 (2) types of waiting periods that GEMS may apply. These are:

- A General Waiting Period (GWP) of up to three (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 claim 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 when the application for membership was made.

Non-disclosure of pre-existing medical conditions

A pre-existing condition is a medical condition that existed before a beneficiary joined the Scheme and for which the beneficiary was receiving medical or surgical treatment. Non-disclosure is the failure of the beneficiary to disclose a pre-existing medical condition on application to join the Scheme.

It is important to note that a monitoring process is in place to identify any pre-existing condition that was not disclosed by a new member, even if underwriting was not imposed. If non-disclosure of a pre-existing medical condition is confirmed, the Scheme will impose underwriting and the resulting waiting periods retrospectively, from the beneficiary's date of registration. Unless eligible for Prescribed Minimum Benefit (PMB) entitlement, GEMS will not cover any costs associated with such conditions during the waiting period and claims that may have been paid prior to the outcome of the non-disclosure investigation may also be reversed. This would mean that the member is liable for such reversed claims.

If it is a Prescribed Minimum Benefit (PMB) condition, PMBs will apply. This is provided that the beneficiary was a member of a medical scheme at any time during the 89 days immediately preceding their GEMS membership application date.

Prescribed **Minimum Benefits**

What conditions should be treated as a PMB?

The specific conditions are defined within the Diagnostic Treatment Pairs (DTPs) and on the Chronic Disease List (CDL). Also, any emergency* medical condition should be considered a PMB.

More information on PMBs, as well as the list of Diagnostic Treatment Pairs and Chronic Disease List is available on the Council for Medical Schemes website. Click here to see the list of all PMB conditions.

*An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death. In an emergency it is not always possible to diagnose the condition before admitting the patient for treatment. However, if doctors suspect that the patient suffers from a condition that is covered by PMBs, the medical scheme has to approve treatment. Schemes may request that the diagnosis be confirmed with supporting evidence within a reasonable period of time.

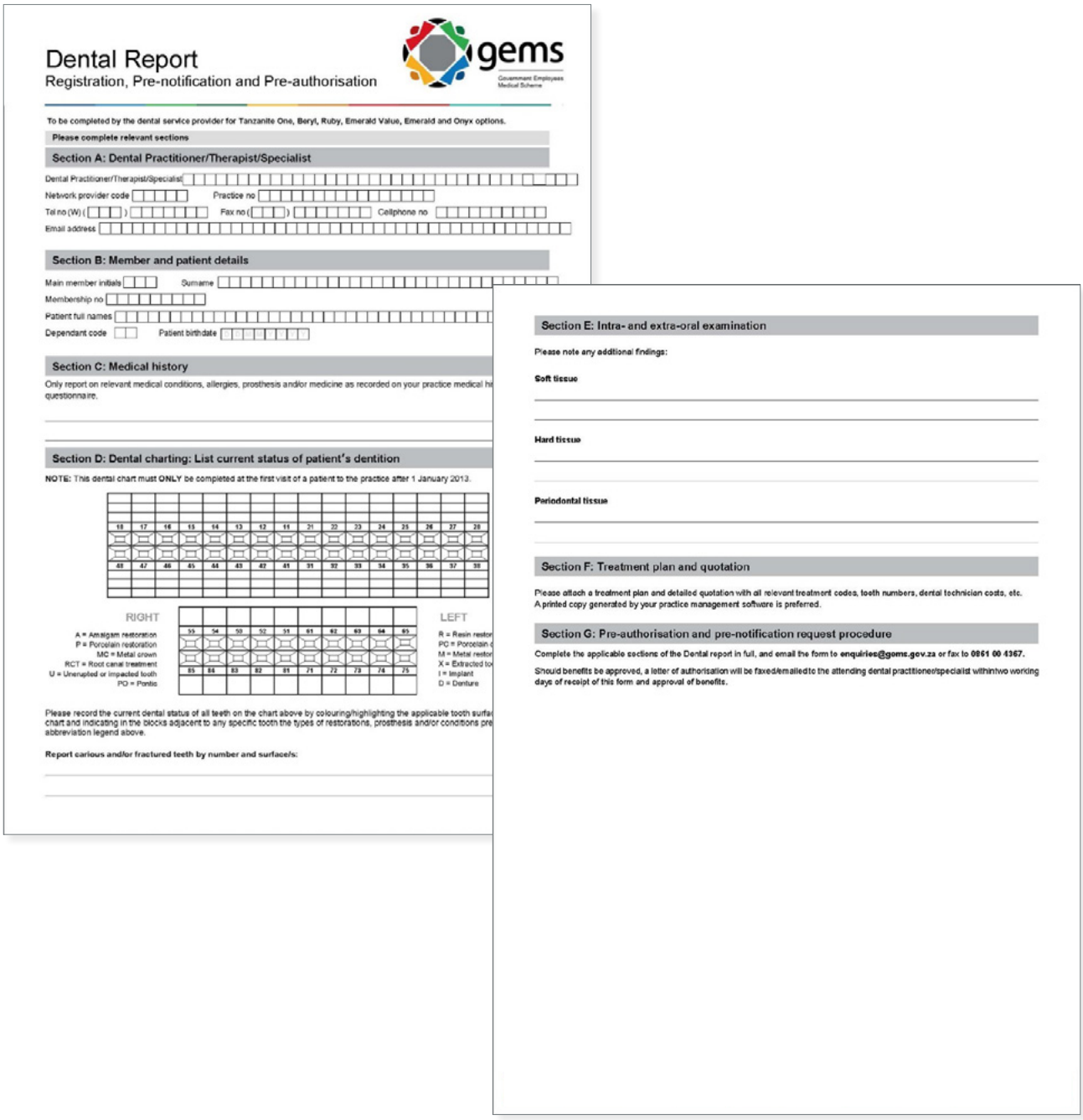
Ex Gratia

Application for an ex gratia consideration for benefits not covered may be lodged with the Scheme in accordance with Scheme rules.

Dental **Report Form**

The ”Dental report” form is used for patient registration during the patient’s first visit to your practice, as well as pre-authorisation applications for certain dental procedures as indicated in this guide.

- The form is available at **www.gems.gov.za.**
- Email the completed form to enquiries@gems.gov.za or fax to **086 100 4367.**



Dental Report

Registration, Pre-notification and Pre-authorisation

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To be completed by the dental service provider for Tanzanite One, Beryl, Ruby, Emerald Value, Emerald and Onyx options.

Please complete relevant sections

Section A: Dental Practitioner/Therapist/Specialist

Dental Practitioner/Therapist/Specialist

Network provider code Practice no

Tel no (W) ( ) Fax no ( ) Cellphone no

Email address

Section B: Member and patient details

Main member initials Surname

Membership no

Patient full names

Dependant code Patient birthdate

Section C: Medical history

Only report on relevant medical conditions, allergies, prosthesis and/or medicine as recorded on your practice medical h
questionnaire.

Section D: Dental charting: List current status of patient’s dentition

NOTE: This dental chart must ONLY be completed at the first visit of a patient to the practice after 1 January 2013.

18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28

48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38

RIGHT

A = Amalgam restoration
P = Porcelain restoration
MC = Metal crown
RCT = Root canal treatment
U = Unerupted or impacted tooth
PO = Pontic

55 54 53 52 51 61 62 63 64 65

85 84 83 82 81 71 72 73 74 75

LEFT

R = Resin restor
PC = Porcelain c
M = Metal restor
X = Extracted to
I = Implant
D = Denture

Please record the current dental status of all teeth on the chart above by colouring/highlighting the applicable tooth surfa
chart and indicating in the blocks adjacent to any specific tooth the types of restorations, prosthesis and/or conditions pre
abbreviation legend above.

Report carious and/or fractured teeth by number and surface/s:

Section E: Intra- and extra-oral examination

Please note any additional findings:

Soft tissue

Hard tissue

Periodontal tissue

Section F: Treatment plan and quotation

Please attach a treatment plan and detailed quotation with all relevant treatment codes, tooth numbers, dental technician costs, etc.
A printed copy generated by your practice management software is preferred.

Section G: Pre-authorisation and pre-notification request procedure

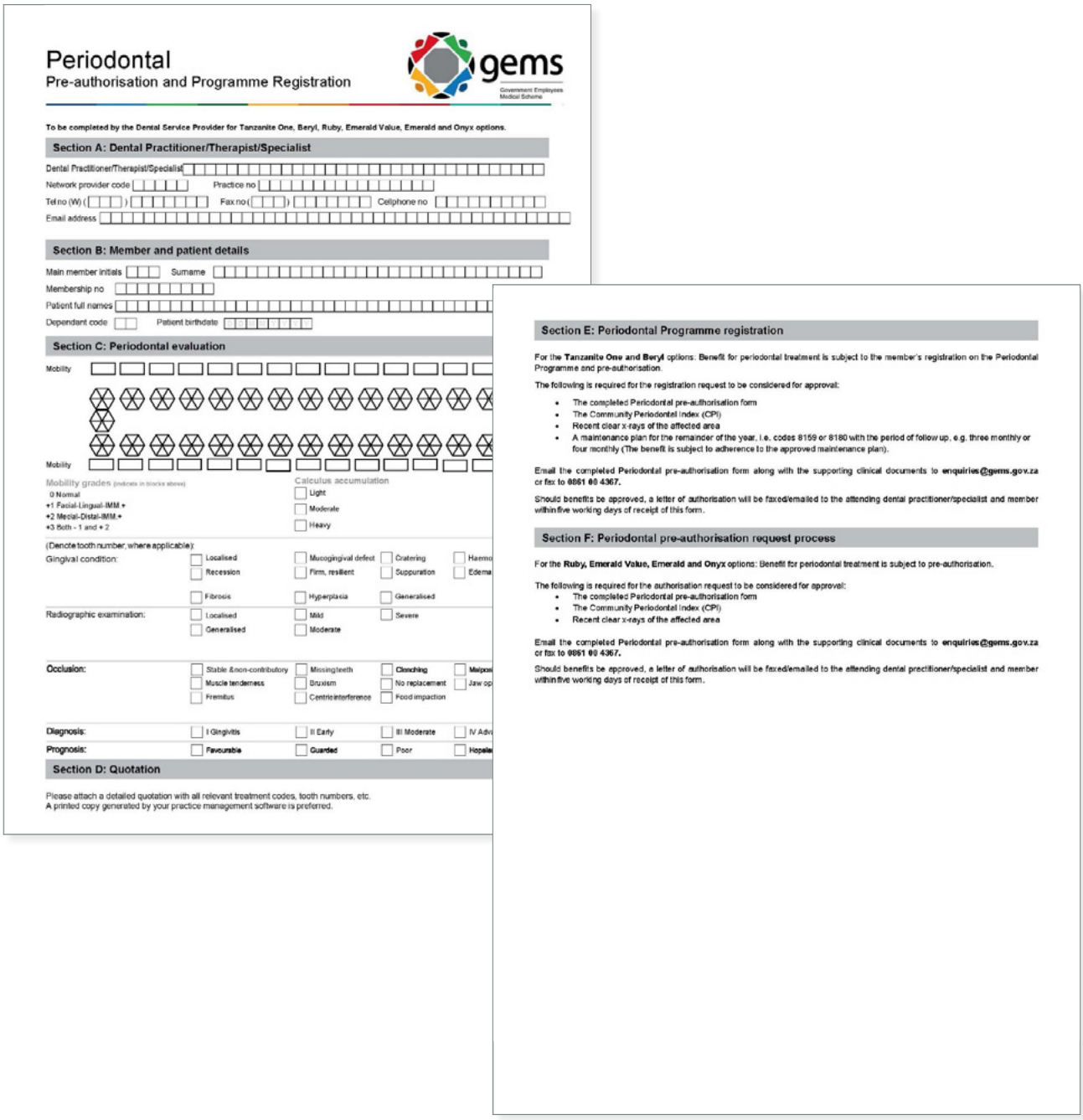
Complete the applicable sections of the Dental report in full, and email the form to enquiries@gems.gov.za or fax to 0861 00 4367.

Should benefits be approved, a letter of authorisation will be faxed/emailed to the attending dental practitioner/specialist within/two working days of receipt of this form and approval of benefits.

Periodontal **Form**

Where pre-authorisation is required for periodontal treatment, the 'Periodontal' form should be completed and forwarded to the Scheme.

- The form is available at **www.gems.gov.za.**
- Email the completed form to enquiries@gems.gov.za or fax to **086 100 4367.**



Periodontal
Pre-authorisation and Programme Registration

gems
Government Employees Medical Scheme

To be completed by the Dental Service Provider for Tanzanite One, Beryl, Ruby, Emerald Value, Emerald and Onyx options.

Section A: Dental Practitioner/Therapist/Specialist

Dental Practitioner/Therapist/Specialist
Network provider code | Practice no
Tel no (W) | Fax no | Cellphone no
Email address

Section B: Member and patient details

Main member initials | Surname
Membership no
Patient full names
Dependant code | Patient birthdate

Section C: Periodontal evaluation

Mobility
Mobility grades (indicate in blocks above)
0 Normal
+1 Facial-Lingual-IMM +
+2 Mesial-Distal-IMM +
+3 Both - 1 and + 2
Calculus accumulation
Light
Moderate
Heavy
(Denote tooth number, where applicable):
Gingival condition: Localised, Recession, Mucogingival defect, Firm, resilient, Cratering, Suppuration, Haemo, Edema, Fibrosis, Hyperplasia, Generalised
Radiographic examination: Localised, Generalised, Mild, Moderate, Severe
Occlusion: Stable &non-contributory, Muscle tenderness, Fremitus, Missing teeth, Bruxism, Centric interference, Clenching, No replacement, Food impaction, Malpos, Jaw op
Diagnosis: I Gingivitis, II Early, III Moderate, IV Adv
Prognosis: Favourable, Guarded, Poor, Hopele

Section D: Quotation

Please attach a detailed quotation with all relevant treatment codes, tooth numbers, etc.
A printed copy generated by your practice management software is preferred.

Section E: Periodontal Programme registration

For the **Tanzanite One and Beryl** options: Benefit for periodontal treatment is subject to the member's registration on the Periodontal Programme and pre-authorisation.

The following is required for the registration request to be considered for approval:

- The completed Periodontal pre-authorisation form
- The Community Periodontal Index (CPI)
- Recent clear x-rays of the affected area
- A maintenance plan for the remainder of the year, i.e. codes 8159 or 8160 with the period of follow up, e.g. three monthly or four monthly (The benefit is subject to adherence to the approved maintenance plan).

Email the completed Periodontal pre-authorisation form along with the supporting clinical documents to **enquiries@gems.gov.za** or fax to **0861 00 4367.**

Should benefits be approved, a letter of authorisation will be faxed/emailed to the attending dental practitioner/specialist and member within five working days of receipt of this form.

Section F: Periodontal pre-authorisation request process

For the **Ruby, Emerald Value, Emerald and Onyx** options: Benefit for periodontal treatment is subject to pre-authorisation.

The following is required for the authorisation request to be considered for approval:

- The completed Periodontal pre-authorisation form
- The Community Periodontal Index (CPI)
- Recent clear x-rays of the affected area

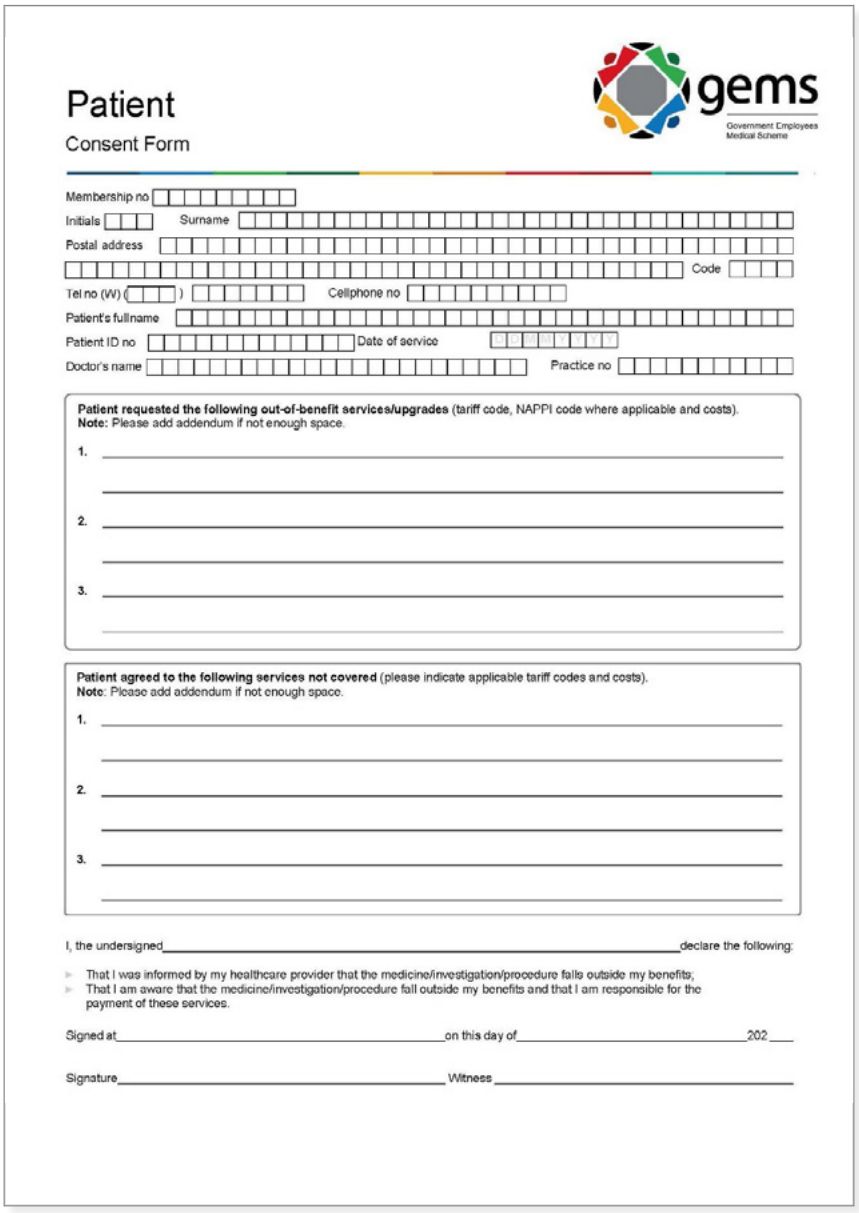
Email the completed Periodontal pre-authorisation form along with the supporting clinical documents to **enquiries@gems.gov.za** or fax to **0861 00 4367.**

Should benefits be approved, a letter of authorisation will be faxed/emailed to the attending dental practitioner/specialist and member within five working days of receipt of this form.

Patient **Consent Form**

When treatment is performed where an exclusion exists, or the patient's benefits have been exceeded, the patient will have to self-fund. Please ensure the 'Patient consent' form for limits exceeded is completed by the patient and kept on file at the practice.

- The form is available at **www.gems.gov.za.**
- Email the completed form to enquiries@gems.gov.za or fax to **086 100 4367.**



Patient

Consent Form

gems

Government Employees Medical Scheme

Membership no

Initials Surname

Postal address

Code

Tel no (W) ( ) Cellphone no

Patient's fullname

Patient ID no Date of service

Doctor's name Practice no

Patient requested the following out-of-benefit services/upgrades (tariff code, NAPPI code where applicable and costs).
Note: Please add addendum if not enough space.

1.

2.

3.

Patient agreed to the following services not covered (please indicate applicable tariff codes and costs).
Note: Please add addendum if not enough space.

1.

2.

3.

I, the undersigned declare the following:

- That I was informed by my healthcare provider that the medicine/investigation/procedure falls outside my benefits;
- That I am aware that the medicine/investigation/procedure fall outside my benefits and that I am responsible for the payment of these services.

Signed at on this day of 202

Signature Witness

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Government Employees Medical Scheme

YOUTUBE
@GEMSMEDICALAID1

Contact details

GEMS Contact Centre

0860 436 777 for provider queries
0860 004 367 for member queries

Monday – Friday: 08h00 – 17h00
Saturday: 08h00 – 12h00
Closed on Sundays and public holidays.

GEMS CONTACT CENTRE
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
0860 44 4367

Access the Provider portal at hcp.gems.gov.za and download the GEMS Provider App from Google Play or the App Store, or use the QR code.

GET IT ON Google Play

Download on the App Store