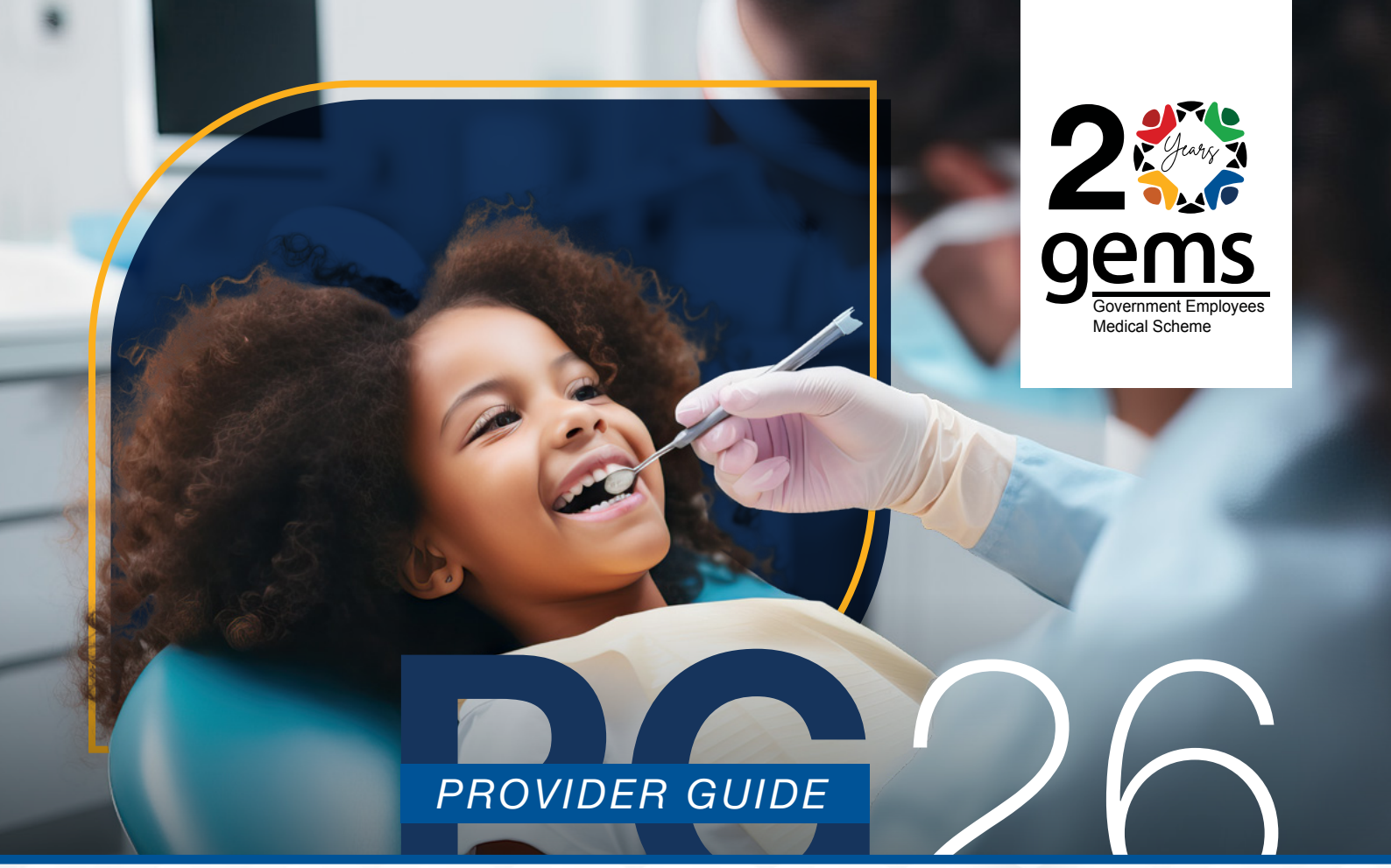

2 Years gems
Government Employees Medical Scheme

PROVIDER GUIDE

DC26

Dental Provider Guide

Assisting healthcare professionals in delivering high-quality, member-centric care.

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01 Introduction

GEMS relies on you, as a valued dental health 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 a summary of the 2026 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 will apply to various dental procedures and the specific application to the different GEMS options, which are Tanzanite One, Beryl, Ruby, Emerald, Emerald Value, and Onyx.

Dental managed care protocols are reviewed throughout the year. Where protocol changes are not included in the annual update of the Provider Guide, GEMS sends correspondence to all claiming dental practices and representing industry associations to notify them of any changes to be implemented.

Please note that the GEMS Dental Provider Guide is not a replacement for the registered Scheme 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.

Note: Should you have any queries regarding the benefits, rules, exclusions, pre-authorisation or your patient's medical scheme option, please contact 0860 436 777 or send an email to enquiries@gems.gov.za (subject line: Dental).

02 What's New in 2026

Below is a list of the 2026 benefit changes applicable to the Dental Benefit. It is important to note that the 2026 benefit changes most significantly impact members on the Tanzanite One and Ruby options. For more detailed information, refer to the relevant sections in this guide.

Tanzanite One

- **Restructuring of Hospital Cover, effective 1 January 2026:** In-hospital benefits are subject to Prescribed Minimum Benefit (PMB) conditions only and subject to PMB legislation. Note that ambulatory dental treatment in a hospital or day facility is allowed for general anaesthesia for children under the age of six (6) years, and removal of impacted teeth, subject to pre-authorisation for a private facility and discharge on the same day.
- Members need to use state or GEMS network hospitals for all admissions. The voluntary use of a non-network private hospital will result in a co-payment of up to R15 000.
- Effective 1 January 2026, Tanzanite One radiology, pathology, and medicine formularies will be restructured. Providers are encouraged to refer to these lists when they request pathology tests and radiology scans for GEMS. All GEMS formulary lists are available at www.gems.gov.za.

Ruby

- Members on the Ruby option need to use hospitals on the GEMS network for all admissions. The voluntary use of a non-network private hospital will result in a co-payment of up to R15 000.

Ruby, Emerald, Emerald Value, Onyx

- The benefit limits for 2026 remain the same as 2025.
- The age rule for Complete Dentures (maxillary and/or mandibular) has been adjusted to a minimum of 21 years for codes 8231 and 8232. An exceptions process is available where a unique case is clinically valid and approved by the GEMS dental advisors.

All Options

- Atraumatic Restorative Treatment (ART): Scope of practice have been extended to all dental disciplines for code 8228. Billing Rules and Managed Care protocols apply.

03 GEMS Practitioner App/ Portal Enhancements

GEMS has enhanced the Practitioner App and Portal. The platforms are more user-friendly and provide a personalised improved user functionality and experience.

The features include:

- ✓ A seamless on-boarding experience that includes user guides and descriptions of the Practitioner App and Portal features.
- ✓ Quick access to membership and benefits confirmation.
- ✓ Claims submissions and access to the GEMS Tariff files.
- ✓ A convenient ICD-10 code search functionality.
- ✓ A document upload section.
- ✓ Practice profile update requests.
- ✓ Provider Frequently Asked Questions (FAQs).

04 GEMS Networks

GEMS Dental Network

For members on the Tanzanite One and Beryl options, dental services must be provided by a dentist, dental therapist, or oral hygienist on the GEMS dental network.

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.

For details and assistance on joining the growing network, please contact 0860 436 777 or send an email to enquiries@gems.gov.za (subject line: Dental Network).

High-quality clinical and administrative service is a team effort between the Scheme and healthcare providers.

GEMS Hospital Networks

- Members on the Tanzanite One, Ruby, and Emerald Value options are subject to the use of a hospital on the applicable GEMS Hospital Network or a state facility for planned in-hospital treatment; 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, Ruby, and Emerald Value members applies to any elective or voluntary use of a non-network hospital or facility. The GEMS Network Hospital lists are available at www.gems.gov.za.
- Members on the Beryl, Emerald, and Onyx options can use private or state facilities for approved elective procedures.
- For PMB-related services in hospital, members on the Beryl, Emerald, and Onyx options are subject to the use of state facilities, and providers on the GEMS Dental Network. In the case of the Tanzanite One, Ruby, and Emerald Value options, members are subject to state facilities or a hospital on the GEMS Hospital Network, and providers on the GEMS Dental Network.
- The Designated Service Providers (DSP) for any in hospital or out-of-hospital PMB services, are providers on the GEMS Dental Network.

05 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 related to code 8101 (as per normal prescribed guidelines for charging of code 8101) needs to be performed and submitted to GEMS.

The 'Dental Report' form for patient registration should be completed and sent to the Scheme:

- The form is available on the GEMS website.
- Email the completed form to enquiries@gems.gov.za (Subject line: Dental) or fax to 0861 00 4367.

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 inter-nationally 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 treatment plan

Pre-authorisation or treatment plans may be required for certain dental procedures as indicated in the procedure schedules in this guide pertaining to each option. They include:

- Any procedures to be performed under conscious sedation, anaesthesia.
- Any procedures to be performed in an operating theatre (general anaesthesia).
- Any treatment in a private hospital or day hospital facility.
- Crown and bridge treatment.
- Implant-supported crowns, bridges and dentures.
- Orthodontics.
- Periodontal disease management.
- Plastic dentures (Tanzanite One and Beryl options).
- Restorations: More than four (4) fillings (Beryl option).
- Surgical procedures: Maxillofacial surgery.
- Surgical procedures: Removal of impacted teeth.

Authorisation for Private Hospital or Day Hospital Facility

Authorisation for hospital admission to a private facility (including facilities on the GEMS Hospital Network lists 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, notify GEMS of such an admission within one (1) working day after the admission, failing which, a co-payment of R1 000 per admission shall apply.

State facilities do not require hospital authorisation from GEMS, however, providers in private practice who utilise state facilities, still need to obtain pre-authorisation.

Pre-authorisation requests

Periodontal disease management

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

Complete and submit the 'Periodontal' form, which can be downloaded from www.gems.gov.za.

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 (subject line: Dental) or fax to 0861 00 4367.

Other authorisation requests

In all other cases where pre-authorisation is required, as specified per benefit 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.

Only complete the applicable sections. It is not necessary to complete the charting section with each request as the initial/same charting section can be used until the completion of the treatment plan.

If you are uncertain whether pre-authorisation is required, contact the call centre on 0860 436 777 to prevent rejection of the patient's account by the Scheme.

Note: The 'Dental report' and 'Periodontal' forms are available at www.gems.gov.za. Email the completed forms to enquiries@gems.gov.za (subject line: Dental) or fax to 0861 00 4367.

06 Access to Benefits

- GEMS members have access to the dental benefits set out in this guide, subject to time and age rules, general industry principles, and the Scheme exclusions.
- Valid claims are paid at the agreed tariff subject to the availability of the dental benefit. Members will be liable for claims relating to benefits that fall 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 a reversal of claims. Also refer to 'Underwriting and Non-disclosure'.

Verification of benefits

- Always ensure that the 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 the 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.

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 the treatment.
- Please ensure the 'Patient Consent' form for limits exceeded is completed by the patient and kept on file at the practice.

Note: The 'Patient consent' form is available at www.gems.gov.za. Email the completed form to enquiries@gems.gov.za (subject line: Dental) or fax to 0861 00 4367.

07 Tanzanite One and Beryl

General administration, benefits, and procedures covered

Benefits for conservative out-of-hospital dental services are available on all options, and include consultations, preventative treatment, dental X-rays, restorations (fillings), tooth extractions, dentures, root canal treatment, and authorised periodontal disease management.

For the Tanzanite One and Beryl options, the out-of-hospital dental services benefit is subject to the list of approved services, managed care protocols and processes, and use of a Dental DSP/Network.

Specialised dentistry benefits are limited to PMBs only.

Refer to the following sections below:

- **Summarised benefit specifications** – Specific rules that apply to the Tanzanite One and Beryl options.
- **Approved service codes and table of benefits** – Tanzanite One and Beryl options.
- **CBCT scans** – Specific rules that apply to the Tanzanite One and Beryl options.
- **Dentures** – Specific rules that apply to the Tanzanite One and Beryl options.
- **Periodontal treatment** – Specific rules that apply to the Tanzanite One and Beryl options.

Summarised Benefit Specifications and Specific Rules that apply

Benefit Specifications	Tanzanite One	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 health practitioner on the GEMS Dental Network.	Services must be provided only by a dental health practitioner on the GEMS Dental Network.
Emergency dentistry: Out-of-network visit	One (1) emergency out-of-network visit per beneficiary per year available for emergency pain and sepsis treatment, including single event root canal treatment as per table of benefits. Other emergency treatment codes covered – • 8201 (extraction of tooth or exposed tooth roots), • 8132 (pulp removal, pulpectomy), and 8307 (pulp amputation, pulpotomy). Any additional treatment requires funding* by patient. *Also refer to Access to benefits: Patient consent form.	One (1) emergency out-of-network visit per beneficiary per year available for emergency pain and sepsis treatment. Emergency treatment codes covered – • 8201 (extraction of tooth or exposed tooth roots), • 8132 (pulp removal, pulpectomy), and 8307 (pulp amputation, pulpotomy). Any additional treatment requires funding* by patient. *Also refer to Access to benefits: Patient consent form.

Benefit Specifications	Tanzanite One	Beryl
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.
Radiology	All the following services apply, subject to an approved list of tariff codes, managed care protocols and processes: • Panoramic radiograph/images 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. • 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*. *Also refer to CBCT scans – Specific Rules that apply to the Tanzanite One and Beryl options.	All the following services apply, subject to an approved list of tariff codes, managed care protocols and processes: • Panoramic radiographs/ images 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. • 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*. Also refer to CBCT scans – Specific Rules that apply to the Tanzanite One and Beryl options.
Restorative treatment	Limited to a maximum of four (4) restorations per beneficiary per year, once per tooth in 720 days.	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 One	Beryl
Root canal treatment	• Services must be provided only by a dental health practitioner on the GEMS Dental Network*. • No benefit for specialist dental disciplines. • 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. • No benefit for retreatment of a previously root canal treated tooth. *Exception is allowed for Tanzanite One – see Emergency dentistry: Out-of-network visit.	• Services must be provided only by dental health practitioner on the GEMS Dental Network. • No benefit for specialist dental disciplines. • 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. • No benefit for retreatment of a previously root canal treated tooth.
Specialised dentistry benefit	• Specialised dentistry benefits are limited to PMBs only. • Orthodontic treatment for beneficiaries on Tanzanite One is a Scheme Exclusion.	• Specialised dentistry benefits are limited to PMBs only. • Orthodontic treatment for beneficiaries on Beryl is a Scheme Exclusion.
Surgical procedures benefit	• Limited to the use of State or Network facility, or rooms of a dental health practitioner on the GEMS Dental Network. • Applicable to surgical removal of impacted teeth under general anaesthesia, or sedation in the rooms; subject to pre-authorisation (for a private facility or practice) and discharge on the same day, relevant managed care protocols, and Scheme rules. • Claims paid at 100% of the Scheme Rate for the removal of impacted teeth. • Other maxillofacial surgery and authorised procedures performed in hospital, are limited to PMBs, and funded in line with Scheme guidelines and PMB legislation.	• Applicable to the following surgical procedures under general anaesthesia[1], or sedation in the rooms[2]: ○ certain maxillofacial surgical procedures. ○ surgical removal of impacted teeth. • Subject to pre-authorisation (for a private facility or practice), relevant managed care protocols, and Scheme rules. • Subject to the surgical procedures sublimit of R29 213 per family per year. *[1] Claims paid at 100% of Scheme Rate* *[2] Claims paid at 200% of Scheme Rate for surgical removal of impacted teeth if authorised under sedation in the rooms (instead of in hospital).*

Benefit Specifications	Tanzanite One	Beryl
General anaesthesia	Subject to Scheme rules, relevant managed care protocols, and authorisation. Benefit for general anaesthesia is only applicable to beneficiaries: • up to (and including) the age of six (6) years, for services classified as conservative or restorative per tariff code, and subject to pre-authorisation for private facilities and discharge on the same day; or • for severe trauma (PMBs). For surgical removal of impacted teeth, refer to Surgical procedures benefit. Other maxillofacial surgery, and authorised procedures performed in hospital, are limited to PMBs, and funded in line with Scheme guidelines and PMB legislation.	Subject to Scheme rules, relevant managed care protocols, and authorisation. Benefit for general anaesthesia is only applicable to beneficiaries: • up to (and including) the age of six (6) years, for services classified as conservative or restorative per tariff code, and subject to pre-authorisation for private facilities and discharge on the same day; or • for severe trauma (PMBs). For surgical removal of impacted teeth, and other maxillofacial surgery, refer to Surgical procedures benefit.
Conscious sedation in the rooms	Benefit for conscious sedation in rooms for dental services 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. For surgical removal of impacted teeth, refer to Surgical procedures benefit.	Benefit for conscious sedation for dental services 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. For surgical removal of impacted teeth, refer to Surgical procedures benefit.

Benefit Specifications	Tanzanite One	Beryl
Hospital network	Ambulatory dental treatment in hospital* and Hospitalisation for PMBs are covered, subject to the use of State or GEMS Network Hospitals, 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 lists are available at www.gems.gov.za *Also refer to Surgical procedures benefit, and General Anaesthesia.	No network applicable for pre-authorised procedures. For PMB, State facilities are the Designated Service Provider (DSP).

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.

Approved service codes and table of benefits

The out-of-hospital dental services benefit is subject to the list of approved services, managed care protocols and processes, and use of a Dental DSP/Network. Specialised dentistry benefits are limited to PMBs only.

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 – bitewing	Maximum of four (4) per beneficiary per year.	Yes	Yes
8115	Panoramic radiograph/image	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 the same year. For beneficiaries aged three (3) to age 16.	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

Code	Code Description	Limitations	COVERED: Tanzanite One	COVERED: Beryl
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	The benefit is only available for patients younger than the age of 18; subject to the use of a Network provider and the relevant managed care protocols: • A maximum of two (2) dental fissure sealants per quadrant on posterior permanent teeth (premolars and molars; excluding 3rd molars) only; and • Limited to once every two (2) years per tooth.	Yes	Yes
Restorations				
8341 8342 8343 8344	Amalgam – one (1) surface Amalgam – two (2) surfaces Amalgam – three (3) surfaces Amalgam – four (4) and more surfaces	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 is needed for more than four (4) fillings.
8351 8352 8353 8354 8367 8368	Resin restoration – one (1) surface, anterior Resin restoration – two (2) surfaces, anterior Resin restoration – three (3) surfaces, anterior Resin restoration – four (4) and more surfaces, anterior Resin restoration – one (1) surface, posterior Resin restoration – two (2) surfaces, posterior	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 is needed for more than four (4) fillings.
8369 8370	Resin restoration – three (3) surfaces, posterior Resin restoration – four (4) and more surfaces, posterior	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 is needed for more than four (4) fillings.

Code	Code Description	Limitations	COVERED: Tanzanite One	COVERED: Beryl
8228	Atraumatic Restorative Treatment (ART)	Included in the overall restorations limit of four (4) per year, and once per tooth in 720 days. Allowed for all Dental disciplines on the network	Yes	Yes
Extractions and surgical extractions				
8201	Extraction of tooth	Any four (4) non-surgical extractions per beneficiary per year; only if clinically indicated. At non-network provider: Only funded as part of one (1) emergency out-of-network visit per beneficiary per year.	Yes	Yes
8937	Surgical removal of erupted tooth – report per tooth	Maximum of two (2) removals. The benefit applies from age 12.	Yes	Yes
8213	Surgical removal of residual tooth roots	Maximum of two (2) procedure – more than one (1) requires clinical motivation. The benefit applies from age 12.	Yes	Yes
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	Once per lifetime per tooth, subject to managed care protocols.	Yes	Yes
Supplementary				
8109	Infection control/ barrier techniques.	Two (2) per visit. Code 8109 includes provision by a dental practitioner of new rubber gloves, masks etc. for each patient.	Yes	Yes
8110	Sterilised instrumentation	One (1) per visit.	Yes	Yes
8145	Local anaesthetic	One (1) per visit.	Yes	Yes

Code	Code Description	Limitations	COVERED: Tanzanite One	COVERED: Beryl
Emergency dentistry (available as part of emergency visit at non-network provider)				
8201	Extraction of tooth or exposed tooth roots	Any four (4) non-surgical extractions per beneficiary per year; only if clinically indicated. At non-network provider: Only funded as part of one (1) emergency out-of-network visit per beneficiary per year.	Yes	Yes
8307	Pulp amputation (pulpotomy)	Two (2) per beneficiary per 12 months; one (1) event per beneficiary per benefit year allowed for emergency dentistry; for primary teeth only. At non-network provider: Only funded as part of one (1) emergency out-of-network visit per beneficiary per year.	Yes	Yes
8132	Pulp removal (pulpectomy)	Once per beneficiary per 12 months; one (1) event per beneficiary per benefit year allowed for emergency dentistry. At non-network provider: Only funded as part of one (1) emergency out-of-network visit per beneficiary per year.	Yes	Yes
Root Canal Treatment				
8303	Pulp cap – indirect	Limited to once per tooth in 720 days; and one (1) complete root canal therapy event (one tooth only) per beneficiary per 12 months.	Yes	Yes
8304	Isolation of tooth/ teeth – per arch	For root canal procedures subject to Tanzanite One and Beryl benefit rules; limited to one (1) event 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

Code	Code Description	Limitations	COVERED: Tanzanite One	COVERED: Beryl
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
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 separated instrument within root 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
Periodontal treatment				
8176	Periodontal examination	One (1) per beneficiary in 365 days	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

Code	Code Description	Limitations	COVERED: Tanzanite One	COVERED: Beryl
8737	Root planing – four (4) or more teeth per quadrant	Subject to pre-authorisation and registration on the Periodontal Programme	Yes	Yes
8739	Root planing – one (1) to three (3) teeth per quadrant	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

Cone Beam Computed Tomography (CBCT) scans

Registration of CBCT machines

Dental providers who utilise and claim for CBCT scans are requested to register their CBCT machines by submitting the following:

- Proof of purchase of the CBCT machine. The purchase record of the CBCT scanner should include the model and serial number as per the manufacturer.
- If the date on the proof of purchase is older than 365 days at the time the documents are received by GEMS, a valid Calibration Certificate (dated within the last 365 days) is required.

Email your proof of purchase or current calibration to enquiries@gems.gov.za with this subject line: DENTAL CBCT Registration.

Benefit for CBCT scans

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. This must be in line with the Scheme Rules and managed care protocols.

A CBCT scan will not be funded if claimed with a panoramic radiograph/image (tariff code 8115) on the same treatment date. Where the benefit is available for code 8115, the claim for the CBCT scan codes will reject and only tariff code 8115 will be funded.

Reimbursement codes for CBCT scans

The table below 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)*

CBCT tariff codes not funded

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.

Codes Not Funded	Procedure Description
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.

Dentures

Benefit Specifications	Tanzanite One	Beryl
Dentures	• Plastic dentures are subject to pre-authorisation. • Only members and beneficiaries over the age of 21 qualify for this benefit. • One (1) set* of plastic dentures is allowed per beneficiary once every 48-month benefit cycle. • Plastic dentures are limited to the approved 2026 Scheme tariff. • No benefit is available for metal frame dentures.	

***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 a partial lower denture
- A complete upper and partial lower denture
- A complete lower and partial upper denture

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.

- When claiming via Electronic Data Interchange (EDI), use individual codes (i.e. 9-codes) for dental laboratories. Laboratory invoices should 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.

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)	

Periodontal treatment

Benefit Specifications	Tanzanite One	Beryl
Periodontal treatment	• The benefit for periodontal treatment is subject to members' registration on the Periodontal Programme (see Registration on the Periodontal Programme), and pre-authorisation; managed care protocols and processes apply. • Additional scaling and polishing benefits are allowed for beneficiaries registered on the Periodontal Programme. • Services must be provided only by a dental health practitioner on the GEMS Dental Network. • No benefit for specialist dental disciplines. • The benefit is limited to non- surgical periodontal treatment.	
Registration on the Periodontal Programme	The benefit for periodontal treatment is subject to pre-authorisation and registration on the Periodontal Programme. Complete the 'Periodontal' form* and forward it to the Scheme along with the supporting records. **The following records are required for registration:** • Community Periodontal Index (CPI) • Clear X-rays of the affected areas (taken within the last three (3) months) • Maintenance plan (8159 or 8180 with the period of follow up, e.g. three • (3) monthly or four (4) monthly) The benefit is subject to adherence to the approved maintenance plan. *The 'Periodontal' form is available at www.gems.gov.za. Email the completed form and supporting documentation to enquiries@gems.gov.za (subject line: Dental).	

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

Periodontal Codes Funded	Periodontal Codes Not Funded
8176 (periodontal examination)	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)

Periodontal Codes Funded	Periodontal Codes Not Funded
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)	8281, 8663, and 8671 (metal base codes) and associated laboratory fees
	8748 (flap operation with root planing and curettage, including bone surgery – four (4) or more teeth per quadrant)
	8749 (flap operation with root planing and curettage (open curettage) - one (1) to three (3) teeth per quadrant)

08 Ruby, Emerald, Emerald Value, and Onyx

General Administration, benefits, and procedures covered

Benefits for conservative out-of-hospital dental services are available on all options, and include consultations, preventative treatment, dental X-rays, restorations (fillings), tooth extractions, dentures, root canal treatment, and authorised periodontal disease management.

In-hospital dentistry professional fees and all out-of-hospital dentistry fees are payable from a shared dental limit per beneficiary.

Also refer to the following sections below for specific limits, benefits covered, and Rules that apply to Ruby, Emerald, Emerald Value, and Onyx:

- Shared Dental Limit
- Summarised Benefits Covered
- Table of Benefits for Conservative Dentistry
- Table of Benefits for Specialised Dentistry
- Table of Benefits for Dental Hospitalisation
- General Authorisation Rules
- CBCT scans
- Dental implants
- Orthodontic treatment
- Hospitalisation

Shared Dental Limit

Ruby	Emerald and Emerald Value	Onyx
Shared dental limit of R4 489 per beneficiary per year for in-hospital dentistry professional fees and all	Shared dental limit of R6 900 per beneficiary per year for in-hospital dentistry professional fees and all out-of-hospital dentistry.	Shared dental limit of R12 310 per beneficiary per year for in-hospital dentistry professional fees and all out-of-hospital dentistry.

Summarised Benefits Covered

Benefits Specifications	Ruby	Emerald and Emerald Value	Onyx
Provider limitations	The services are not limited to GEMS Dental Network providers.		
Conservative and restorative dentistry (including plastic dentures)	100% of Scheme rate, subject to the available funds.		
Preventative care services benefit for dental fissure sealants	• The benefit for dental fissure sealants is available to a maximum of two (2) per quadrant, once every two (2) years per tooth, and only available for beneficiaries younger than 18 years of age. • Dental fissure sealants are funded from the Preventative Care Services benefit, not the shared dental limit, on the Ruby, Emerald, Emerald Value, and Onyx options. • This benefit enhancement is applicable to beneficiaries younger than 18 years of age, subject to the 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 limit and not the Preventative Care Services benefit.		
Preventative care services benefit for dental polishing	• Dental polishing (code 8155) for beneficiaries from the age of three (3) to nine (9) years (both inclusive) is funded from the Preventative Care Services benefit, not the shared dental limit, on the Ruby, Emerald, Emerald Value, and Onyx options. • Code 8155 for all other covered beneficiaries is payable from the available shared dental limit.		
Specialised dentistry (including metal base partial dentures)	**Partial metal base dentures:** • No pre-authorisation is required for partial metal base dentures. • Metal frames for partial dentures are limited to one (1) per jaw, and once every five (5) years. **Specialised dentistry authorisation:** • Pre-authorisation is required for all other specialised dentistry procedures. • Implant supported crowns, bridges, and dentures are subject to pre-authorisation. **Exclusions:** • Excludes orthodontic treatment for patients who are 21 years of age and older. • First and second phases of implant procedures, and orthognathic surgery are a Scheme exclusion.		

Benefits Specifications	Ruby	Emerald and Emerald Value	Onyx
Surgical procedures benefit	• Applicable to the following surgical procedures under general anaesthesia[1], or sedation in the rooms[2]: ○ certain maxillofacial surgical procedures. ○ surgical removal of impacted teeth (in and out-of-hospital). • Subject to pre-authorisation, relevant managed care protocols and Scheme Rules. • For Ruby or Emerald Value, limited to the use of State or Network facility, or practitioner's rooms. *[1] Claims paid at 100% of Scheme Rate, subject to surgical procedures benefit (not shared dental limit).* *[2] Claims paid at 200% of Scheme Rate for surgical removal of impacted teeth if authorised under sedation in the rooms, subject to surgical procedures benefit (not shared dental limit).*		
Conscious sedation in the rooms for conservative and restorative dentistry	• The benefit for conscious sedation in the rooms for conservative and restorative dentistry 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. • Professional fees are subject to the shared dental limit. • Anaesthetists are required to obtain a separate authorisation for dental-related conscious sedation procedures. For surgical removal of impacted teeth, refer to Surgical Procedures benefit		
General anaesthesia	• General anaesthesia is only applicable to the following beneficiaries: ○ up to and including the age of six (6) years ○ with severe trauma • Subject to Scheme Rules, relevant managed care protocols and pre-authorisation. • Professional fees, subject to shared dental limit. For surgical removal of impacted teeth, refer to Surgical Procedures benefit		

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.

Table of Benefits for Conservative Dentistry

Conservative Dentistry	Ruby	Emerald and Emerald Value	Onyx
Dental consultation yearly check-up	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. 8108 (Intraoral radiographs/ images – 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. 8115 (Panoramic radiograph/ image): The benefit applies from age six (6) – maximum one (1) every 36 months. 8116 (Cephalometric radiograph/image), 8114 (Extraoral radiograph): For orthodontic treatment only.		
Infection control	8109 (Infection control/ barrier techniques): Twice per visit 8110 (Sterilised instrumentation): Once per visit		
Preventative dentistry	8163 (Dental sealant – per tooth): • Maximum of two (2) dental fissure sealants per quadrant on posterior permanent teeth (premolars and molars; excluding 3rd molars) only, 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 8155 (Polishing): Once every six (6) months. For beneficiaries from the age of three (3) to the age of 16. 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		
Restorations/fillings	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 Complete dentures - Only members and beneficiaries over the age of 21 qualify for this benefit. An exceptions process is available where a unique case is clinically valid and approved by the GEMS dental advisors.		
Endodontic (root canal) treatment	8132 (Pulp removal – pulpectomy) not allowed on the same day as root treatment		

Table of Benefits for Specialised Dentistry

Conservative Dentistry	Ruby	Emerald and Emerald Value	Onyx
Crowns and bridges	Pre-authorisation is required, and the benefit is 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 limit		
Orthodontics	A treatment plan is required, and the benefit is limited to patients under 21 years of age. (Also refer to Orthodontic treatment – Specific rules that apply to Ruby, Emerald, Emerald Value and Onyx)		
Periodontics	A treatment plan is required, and the treatment is subject to managed care protocols.		
Maxillo-facial & oral/dental surgery	Certain maxillofacial surgical procedures, and surgical removal of impacted teeth (in and out-of-hospital). Pre-authorisation is required when done in theatre or under sedation in the rooms; surgical removal of impacted teeth paid at 200% of rate when performed under sedation in dentist's rooms. (Also refer to Summarised Benefits Covered – Ruby, Emerald, Emerald Value and Onyx: Surgical procedures benefit)		

Table of Benefits for Dental Hospitalisation

Dental Hospitalisation	Ruby	Emerald and Emerald Value	Onyx
Dental hospitalisation	For patients up to and including the age of six (6); or severe trauma (PMB). Subject to pre-authorisation, treatment protocols and PMB conditions. For surgical removal of impacted teeth, refer to Summarised Benefits Covered – Ruby, Emerald, Emerald Value and Onyx: Surgical procedures benefit		

Note: For members on the Ruby and Emerald Value options, the use of a non-network hospital may attract a co-payment of up to R15 000.

General Authorisation Rules

- All dental procedures are covered by the rules applicable to the specific Scheme benefit option.
- All specialised dentistry and in-hospital dentistry are subject to pre-authorisation before the 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. The 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. The 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.

Cone Beam Computed Tomography (CBCT) scans

Registration of CBCT machines

Dental providers who utilise and claim for CBCT scans are requested to register their CBCT machines by submitting the following:

- Proof of purchase of the CBCT machine. The purchase record of the CBCT scanner should include the model and serial number as per the manufacturer.
- If the date on the proof of purchase is older than 365 days at the time the documents are received by GEMS, a valid Calibration Certificate (dated within the last 365 days) is required.

Email your proof of purchase or current calibration to enquiries@gems.gov.za with this subject line: DENTAL CBCT Registration.

Benefit for CBCT scans

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

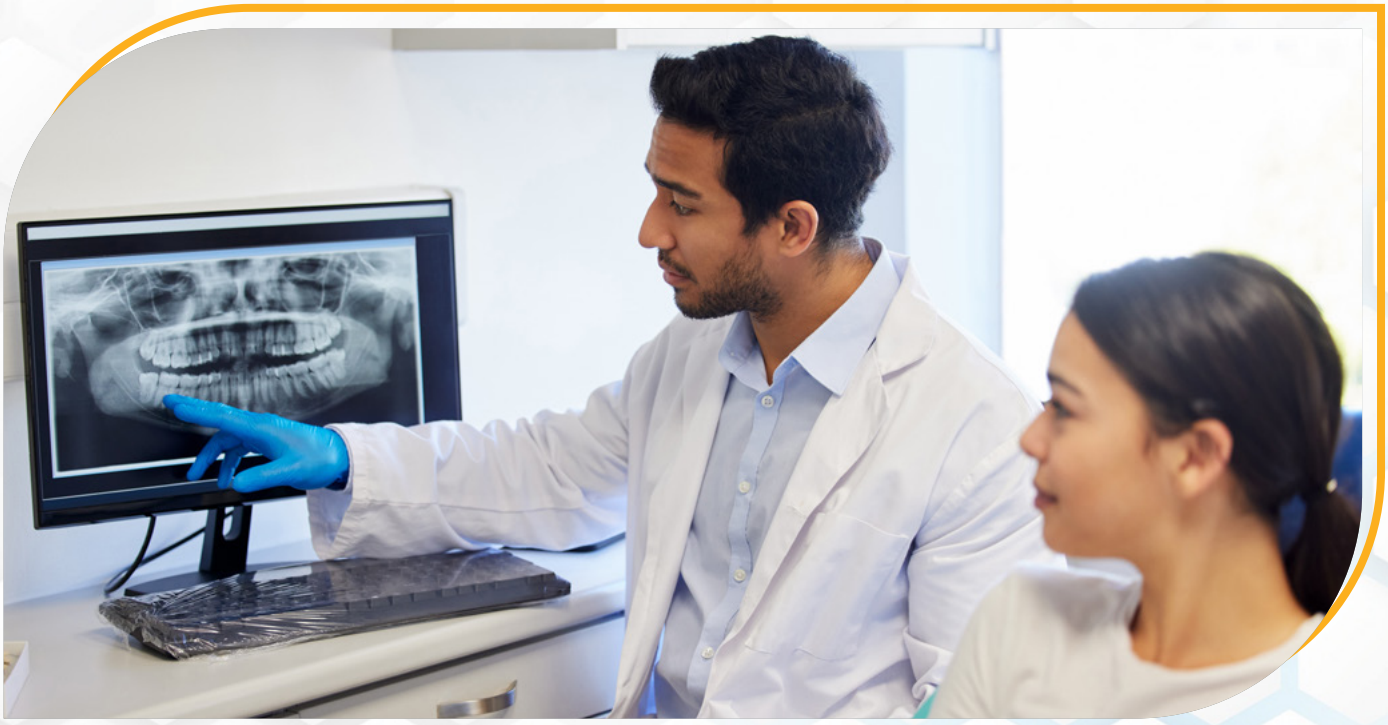
Note that a CBCT scan will not be funded if claimed with a panoramic radiograph/image (tariff code 8115) on the same treatment date. Where the benefit is available for code 8115, the claim for the CBCT scan codes will be rejected and only tariff code 8115 will be funded.

Reimbursement codes for CBCT scans

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)*



CBCT tariff codes not funded

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.

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 limit 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 (if authorised)
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)

Orthodontic treatment

- Only members and beneficiaries under the age of 21 qualify for the benefit for orthodontic treatment.
- Authorisation and a treatment plan are required, and the benefits are subject to prior evaluation according to the Index of Complexity, Outcome and Treatment Need (ICON) criteria.
- The following records are required for orthodontic approval:
  - Treatment plan and detailed quotation including the initial fee and monthly fees.
  - Pre-treatment photographs showing a full occlusal view of the mandibula and the maxilla.
  - Cephalometric radiograph
  - Cephalometric tracing
  - Panoramic radiograph
- 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 only be covered 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 availability of funds from the beneficiary's shared dental limit.
- 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 remaining balance due as per the original treatment plan will be covered.
- When you are 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.
- Also refer to 'General exclusions and restrictions: Orthodontic treatment'.

Hospitalisation

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

09 General Exclusions and Restrictions

All GEMS Options

Please refer to the summary of benefits, detailed procedure benefit lists/schedules, and 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.

Beneficiaries shall be entitled to Prescribed Minium Benefits as set out in the Scheme Rules. The exclusions and restrictions of benefits listed do not apply to PMBs.

The Scheme shall not pay the costs for services rendered in respect of the Dentistry and Maxillofacial Surgery Exclusions listed below:

Crown and Bridge exclusions

- Cost of gold, semi-precious metal and platinum foil
- Emergency crowns not placed for immediate protection of injured teeth
- For cosmetic reasons
- On a failed root canal-treated tooth
- On primary teeth or third molars
- Pontics on second molars
- Temporary and provisional crowns, including laboratory costs
- Where a lack of remaining tooth structure compromises an acceptable prognosis
- Where an underlying periodontal condition (e.g. extensive loss of alveolar bone) compromises an acceptable term prognosis
- Where enough remaining tooth structure does not justify a crown as the restoration of choice

Dentures exclusions

- Clasp or rest – cast gold
- Clasp or rest – wrought gold
- Diagnostic dentures
- Inlay in denture
- Metal base to full dentures
- Snoring apparatus

Diagnostic/Preventative Treatment exclusions and restrictions

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

Endodontic Treatment exclusions and restrictions

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

Fillings and Restorations exclusions

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

Implant-related exclusions and restrictions

- 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.

In-Hospital (Theatre) exclusions and restrictions

- General anaesthetics, and hospitalisation for dental work are only allowed for beneficiaries up to and including the age of six (6) years; or bony impactions; or severe trauma as per Scheme Rules – no other dental procedures apply.
- Only dental services classified as conservative, restorative and specialised per tariff code are funded. Preventative dental procedures (i.e. polish, fluoride treatment, dental sealants) as part of the dental treatment performed under general anaesthetic on children up to and including the age of six (6) years are excluded.

Inlays and Onlays exclusions and restrictions

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

Orthodontic treatment exclusions and restrictions

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

Other exclusions and restrictions

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

10 GEMS Formulary Lists

GEMS Acute Medication Formulary

Medicine may be prescribed by a dentist or dental therapist (within his/her scope as per the latest government gazette published by the Department of Health), and according to the GEMS Acute Medication formulary per option.

For acute medicines, only cost-effective generics will be covered under Tanzanite One and Beryl.

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

Refer to the Acute Medicine formulary per option. All GEMS formulary lists are available at www.gems.gov.za.

Out-of-Hospital Pathology and Radiology Formularies

For the Tanzanite One option, only tests and radiology procedures listed in the Tanzanite One formularies will be fully funded. Any out-of-formulary items will be declined.

For the Beryl option, out-of-formulary tests and radiology will attract a member co-payment. Refer to the Beryl formularies.
General X-rays (e.g. of facial bones and the skull) and standard histology pathology remain in-formulary.

Refer to the Pathology Formulary, and Radiology Formulary per option. All GEMS formulary lists are available on the GEMS website.

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 Medicine Price Lists (MPLs) and Medicine Exclusion Lists (MELs). Note that provider trade names are not listed on formulary, allowing for generic substitution, but applying MPLs and 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.

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.

11 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 (BHF) 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 your practice 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.

12 Prescribed Minimum Benefits

What conditions should be treated as a PMB?

The specific conditions are defined within the Diagnostic Treatment Pairs (DTP) 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. Schemes may request that the diagnosis be confirmed with supporting evidence within a reasonable period of time.

13 Underwriting and Non-disclosure

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)

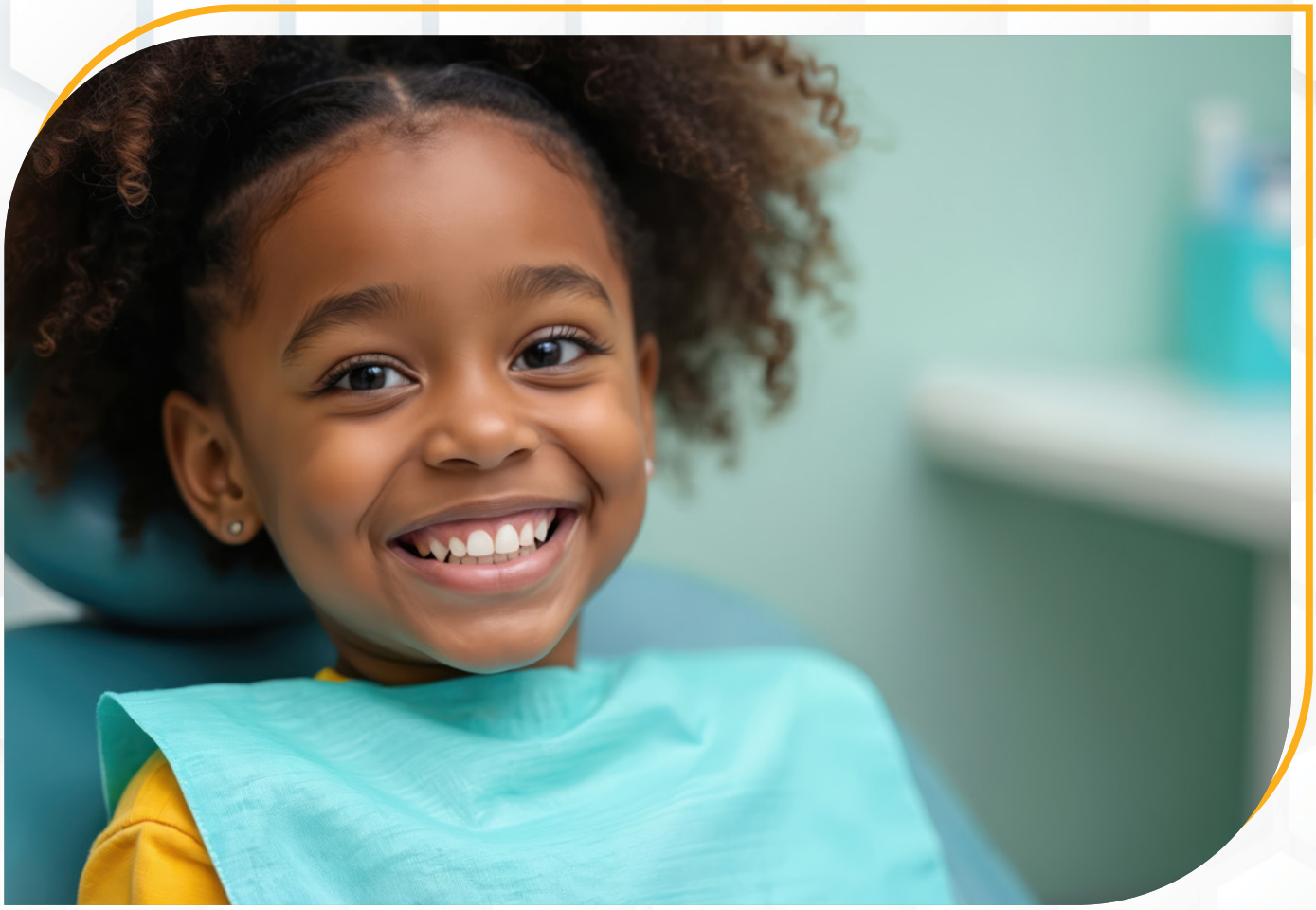
Up to three (3) months

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 Condition-Specific Waiting Period (CSWP)

Up to 12 months

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 in their 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 in their application for membership, 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.

14 Ex Gratia

Ex Gratia Applications

Application for consideration for ex gratia funding for dental benefits not covered may be lodged with the Scheme in accordance with Scheme Rules.

Ex gratia funding is a concession exercised at the sole discretion of the GEMS Ex Gratia Committee.

Kindly await the outcome of the decision before proceeding with the treatment.

15 Useful Resources

SERVICE	PURPOSE	TELEPHONE	EMAIL ADDRESS/LINKS FOR QUERIES
GEMS contact centre	General queries related to GEMS	0860 436 777	enquiries@gems.gov.za
GEMS website	View GEMS products and services	-	www.gems.gov.za
GEMS tariff file, formularies and forms	To view GEMS tariff file, formularies and forms	-	www.gems.gov.za, select Healthcare Providers > Select either Tariff file, Formulary Lists or ICD-10 Codes from the menu.
GEMS network contract management and Provider Liaison Consultants	Contracting queries, REPl2 categorisation queries or Provider Liaison Consultant assistance	-	networkscontracting@gems.gov.za
Chronic medicine management – new registrations and updates	Chronic registrations	0860 436 777	chronicdsp@gems.gov.za
Chronic medicine authorisation queries	Queries related to the authorisation of chronic medicines	0860 436 777	chronicauths@gems.gov.za
Fraud Hotline	Fraud-related matters	0800 212 202	gems@thehotline.co.za office@thehotline.co.za
Hospital pre-authorisation	All hospital pre- authorisations for non- emergency events	0860 436 777	hospitalauths@gems.gov.za
Submission of claims	Submissions of claims for GEMS beneficiaries	0860 436 777	enquiries@gems.gov.za
Queries of claims	Queries relating to a claim for a GEMS beneficiary	0860 436 777	enquiries@gems.gov.za
Oncology services	Oncology-related queries	0860 436 777	oncologyauths@gems.gov.za
Ambulatory PMB	Out-of-hospital PMB queries	0860 436 777	enquiries@gems.gov.za
HIV/Aids management	HIV/AIDS related queries	0860 436 736	hiv@gems.gov.za

16 Upcoming Events in 2026

Annual GEMS Stakeholder Golf Day

20 March 2026 – KwaZulu-Natal

2026 GEMS Healthcare Practitioner Summits

28 March 2026 – Western Cape

25 July 2026 – Eastern Cape

16 May 2026 – Limpopo

19 September 2026 – Free State

2026 Dental Health Practitioner Roadshows

GEMS will share details of the 2026 Dental Health Practitioner Roadshows when the dates are finalised. Keep a lookout for communication details of upcoming events in your province.

Contact Details:

GEMS CONTACT CENTRE - 0860 436 777

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 (toll-free)
gems@thehotline.co.za

GEMS EMERGENCY SERVICES - 0800 44 4367 (toll-free)
ICT Service desk - (012) 366 4618

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Disclaimer

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