ANNEXURE C 2026

BERYL

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

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

REGISTERED BY ME ON
Mondi Govuzela
2025/11/28
Signed by Mondi Govuzela
M.Govuzela@medicalschemes.co.za
02/12/2025 21:20:30(UTC+02:00)
SIGNIFLOW
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				▪ a Designated Service Provider (“DSP”) for that condition; ▪ a non-DSP, if no DSP for that condition exists; or ▪ a non-DSP involuntarily, as described in Regulation 8 (3) of the General Regulations promulgated under the Medical Schemes Act 131 of 1998 (as amended), subject to: ▪ Authorisation, managed care protocols, formulary and

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				processes, as specified under B: In-Hospital Benefits and C: Out-of-Hospital Benefits; and ▪ The Act. • This Rule supersedes all other benefit provisions in this Annexure.
B	**IN-HOSPITAL BENEFITS**	100% of Scheme Rate, subject to PMBs.	Subject to overall hospital limit of R1 460 702 per family per annum and such sub-limits as provided for.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs").
B1	**Public Hospitals, Private Hospitals, Registered Unattached Theatres, Day**	100% of Scheme Rate, subject to PMBs.	Subject to annual hospital limit specified under B: In-Hospital Benefits.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs").

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	Clinics and Psychiatric Facilities: 1. Accommodation in a general ward, high care ward and intensive care unit (ICU); 2. Theatre fees; 3. Medicines, materials and hospital equipment (includes bone cement for prostheses (B14)); 4. Confinements and midwives; and 5. Neonatal care.			• Hospital authorisation for admission to a Private facility must be obtained from the Scheme's managed care service provider at least 48 hours before a Beneficiary is admitted to a Private facility (except in the event of an Emergency Medical Condition), failing which, a co-payment of R1 000 per admission shall apply. • In the event of an admission to a Private facility for an Emergency Medical Condition, the Scheme must be notified of such admission within

REGISTERED BY ME ON
Mondi Govuzela
2025/11/28
Signed by Mondi Govuzela, M.Govuzela@medicalschemes.co.za
02/12/2025 21:21:37(UTC+02:00)
SIGNIFLOW
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				one (1) working day after the admission, failing which, a co-payment of R1 000 per admission shall apply. • All In-Hospital treatment and services are subject to hospital authorisation (for Private facilities only, and inclusive of non-PMB one-day admissions), managed care protocols and processes. • TTO limited to seven (7) days, subject to medication being related to admission diagnosis. • A co-payment of R1000 per scope shall apply in

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				respect of all non-PMB / elective scopes performed in acute hospitals.
B2	**Maternity** Hospital, home birth or accredited birthing unit.	100% of cost, but subject to PMB legislation.	Unlimited, but subject to PMB legislation.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to managed care protocols and processes. • Hospital authorisation for admission to a Private facility must be obtained from the Scheme's managed care service provider at least 48 hours before a Beneficiary is admitted to a Private facility (except in the event of an Emergency Medical

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				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. • Elective Caesarean Sections may be subjected to second opinion and managed

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				care protocols and processes. • Benefit includes midwife services. • Includes non-invasive prenatal testing for high-risk pregnancies, subject to pre-authorisation.
B3	**Family Practitioner Services** Consultations and visits.	100% of Scheme Rate for non-Network Family Practitioners. 130% of Scheme Rate for Network Family Practitioners.	Subject to annual hospital limit specified under B: In-Hospital Benefits. Reimbursement according to Scheme-approved tariff file. Childbirth by a Family Practitioner.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to Private hospital pre-authorisation and use of facility as per B1.

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B4	**Specialist Services** Consultations and visits.	100% of Scheme Rate for non-Network Specialists. 130% of Scheme Rate for Network Specialists.	Subject to annual hospital limit specified under B: In-Hospital Benefits. Reimbursement according to Scheme-approved tariff file.	• All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). • Subject to Private hospital pre-authorisation and use of facility as per B1.
B5	**Surgical Procedures**	100% of Scheme Rate. 200% of Scheme Rate for procedures specified by managed care, performed in practitioners’ rooms instead of in hospital.	Subject to annual hospital limit specified under B: In-Hospital Benefits. Maxillofacial surgery and surgical removal of impacted teeth, subject to an annual sub-limit of R29 213 per family. Refer to Annexure E (Exclusions and	• All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). • Subject to Private hospital pre-authorisation, managed care protocols and processes, and use of facility as per B1, or practitioners’ rooms. • Includes:

REGISTERED BY ME ON
Mondi Govuzela
2025/11/28
Signed by Mondi Govuzela, M.Govuzela@medicalschemes.co.za 02/12/2025 21:22:41(UTC+02:00) SIGNIFLOW
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			Limitations) of GEMS Rules.	○ Hospital procedures performed in practitioners' rooms, as approved by the Scheme; ○ Maxillofacial Surgery; and ○ Surgical removal of impacted teeth (In-Hospital and Out-of-Hospital).
B6	**Dentistry** Conservative and Restorative Dentistry. Surgical Procedures.	100% of Scheme Rate.	Subject to annual hospital limit specified under B: In-Hospital Benefits, and Out-of-Hospital dentistry limits specified under C5: Dental Services.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to Private hospital pre-authorisation, managed care protocols

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	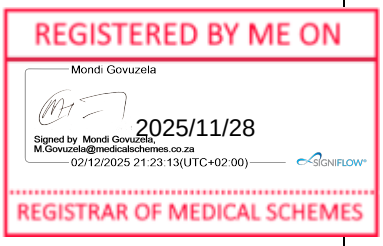		Dental Sealants: Excluded under B6: Dentistry and C5: Dental Services, but included under C3: Preventative Care Services for Beneficiaries under 18 years of age. Refer to Annexure E (Exclusions and Limitations) of GEMS Rules.	and processes, list of approved services, Dental DSP/Network, and use of facility as per B1. • General Anaesthesia and Conscious Sedation: Only applicable to Beneficiaries:- ○ up to and including the age of six (6) years; or ○ with severe trauma, subject to pre-authorisation and managed care protocols and processes. • Dental services classified as conservative, restorative and specialised per tariff code.

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B7	**Basic Radiology**	100% of Scheme Rate.	Subject to annual hospital limit specified under B: In-Hospital Benefits.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to managed care protocols and processes, and use of facility as per B1.
B8	**Advanced Radiology**	100% of Scheme Rate, subject to PMB.	Subject to: • Annual hospital limit specified under B: In-Hospital Benefits; • Sub-limit of R15 183 per Family per annum; and • Further sub-limit of one (1) Computed Tomography (CT) or Magnetic Resonance	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to Advanced Radiology pre-authorisation (in addition to Private hospital pre-authorisation), managed care protocols and processes, list of

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			Imaging (MRI) scan per Beneficiary per annum, all of which limits are shared between B8: Advanced Radiology and C8: Advanced Radiology.	approved services, and use of facility as per B1.
B9	**Pathology**	100% of Scheme Rate.	Subject to annual hospital limit specified under B: In-Hospital Benefits.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to managed care protocols and processes, pathology tests being related to admission diagnosis, and use of facility as per B1.

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B10	**Blood Services**	100% of Scheme Rate, subject to PMBs.	Unlimited, but subject to PMB legislation.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to managed care protocols and processes. • Includes cost of blood, blood equivalents, blood products and the transport thereof. • Includes Erythropoietin.
B11	**Physiotherapy**	100% of Scheme Rate, subject to PMBs.	Subject to annual hospital limit specified under B: In-Hospital Benefits, and sub-limit of R6 344 per Beneficiary per annum.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to Private hospital pre-authorisation, managed care protocols

REGISTERED BY ME ON
Mondi Govuzela
2025/11/28
Signed by Mondi Govuzela, M.Govuzela@medicalschemes.co.za
02/12/2025 21:23:52(UTC+02:00)
SIGNIFLOW
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				and processes, services being related to admission diagnosis, and use of facility as per B1.
B12	**Post Hip, Knee and Shoulder Replacement or Revision Surgery Physiotherapy**	100% of Scheme Rate.	Limited to 10 post-surgery physiotherapy visits (shared with C15: Post Hip, Knee and Shoulder Replacement or Revision Physiotherapy) up to a limit of R7 044 per Beneficiary per event, utilised within sixty (60) days of surgery.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to Private hospital pre-authorisation, managed care protocols and processes, and use of facility as per B1.
B13	**Organ and Tissue Transplants**	100% of Scheme Rate, subject to PMBs.	Limit of R824 901 per Beneficiary per annum. Sub-limit of R28 001 per Beneficiary per annum	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs").

REGISTERED BY ME ON
Mondi Govuzela
2025/11/28
Signed by Mondi Govuzela, M.Govuzela@medicalschemes.co.za
02/12/2025 21:24:00(UTC+02:00)
SIGNIFLOW
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			for corneal grafts (imported corneal grafts, subject to managed care protocols.).	• Subject to Private hospital pre-authorisation, managed care protocols and processes, and use of facility as per B1. • Limit includes all costs associated with the transplant, including materials and immunosuppressants. • Erythropoietin included in B10: Blood Services. • Organ harvesting is limited to the Republic of South Africa, except in the case of cornea grafts.
B14	**Prostheses**	100% of Scheme Rate, subject to PMBs.	Subject to:	• All limits are subject to A: Statutory Prescribed

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	This benefit covers temporary and permanent prostheses and internal devices (surgically implanted), and accompanying temporary and permanent devices used to assist with the guidance, alignment or delivery of these prostheses and internal devices.		• Annual hospital limit specified under B: In-Hospital Benefits; • Sub-limits of R43 823 per family per annum for Prostheses generally, plus R43 823 per family per annum for Joint Revisions only; and • Shared sub-limits with C16: Medical and Surgical Appliances and Prostheses of: o R6 164 per Beneficiary per annum for foot	Minimum Benefits (“PMBs”). • Subject to managed care protocols and processes, and use of facility as per B1. • Scheme may obtain competitive quotes or arrange supply of prosthesis. • Bone cement paid from B1, subject to hospital pre-authorisation. • Foot orthotics and prosthetics, subject to formulary and managed care protocols and processes.

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			orthotics and prosthetics, with a sub-limit of R1 761 per Beneficiary per annum for orthotic shoes, foot/shoe/ankle inserts and levelers; o R701 for crutches per Beneficiary per annum; o One (1) wheelchair of up to R7 716 per Beneficiary every thirty-six (36) months of month of receipt of wheelchair; o One (1) unilateral hearing aid, or one	• Subject to the prostheses and/or device(s) being related to the admission diagnosis and procedure. • Once the limit is depleted, the benefit is unlimited for PMBs.

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			(1) pair of bilateral hearing aids, of up to R11 223 per hearing aid per Beneficiary every thirty-six (36) months of month of receipt of hearing aid(s); o One (1) CPAP, APAP, BIPAP or VPAP device (including accessories) of up to R13 328 per Beneficiary every thirty-six (36) months of month of receipt of device;	

REGISTERED BY ME ON
Mondi Govuzela
2025/11/28
Signed by Mondi Govuzela, M.Govuzela@medicalschemes.co.za
02/12/2025 21:24:58(UTC+02:00)
SIGNIFLOW
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			○ Three (3) pairs of compression stockings of up to R584 per pair per Beneficiary per annum; ○ One (1) Pulse Oximeter of up to R467 per family per annum; and ○ One (1) knee and one (1) back brace of up to R3 499 per brace per Beneficiary per annum.	
B15	**Emergency Services (Casualty Department)**	100% of cost, but subject to PMB legislation.	Limited to PMBs (Emergency Medical Condition, as defined in Section 4 of the main	• All limits are subject to A: Statutory Prescribed

REGISTERED BY ME ON
Mondi Govuzela
Signed by Mondi Govuzela
M.Govuzela@medicalschemes.co.za
02/12/2025 21:25:13(UTC+02:00)
2025/11/28
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			body and Annexure G of the GEMS Rules).	Minimum Benefits ("PMBs"). • Subject to use of facility as per B1, or other registered emergency facility. • Subject to Private hospital authorisation and managed care protocols and processes.
B16	**Renal Dialysis** In-Hospital	100% of Scheme Rate, subject to PMBs.	Subject to annual hospital limit specified under B: In-Hospital Benefits, and sub-limit of R292 135 per family per annum for chronic dialysis.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to Private hospital pre-authorisation, managed care protocols

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			Acute dialysis included in B1.	and processes, and use of facility as per B1. • Includes related materials, and related pathology and radiology tests, but subject to managed care protocols and processes. • Erythropoietin included in B10: Blood Services. • Once the limit is depleted, the benefit is unlimited for PMBs.
B17	**Oncology (Chemo and Radiotherapy)** In- and Out-of-Hospital	100% of Scheme Rate, subject to PMBs.	Subject to annual hospital limit specified under B: In-Hospital Benefits, and sub-limit of R292 135 per family per annum.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to Oncology pre-authorisation and

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				managed care protocols and processes. • Subject to Medicine Price List (MPL). • Subject to use of facility as per B1. • Includes cost of pathology, related basic/advanced radiology, medical technologists, oncology medicines and materials. • Erythropoietin included in B10: Blood Services. • Once the limit is depleted, the benefit is unlimited for PMBs.

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				• Excludes new chemotherapeutic medicines that have not convincingly demonstrated a survival advantage of more than three (3) months in advanced or metastatic solid organ malignant tumours, unless pre-authorised in accordance with paragraph 9.1.13.6 of Annexure E Exclusions and Limitations) of GEMS Rules.
B18	**Mental Health** Accommodation, theatre fees, medicine, hospital equipment, professional fees of Family	100% of Scheme Rate, subject to PMBs.	Subject to: • Annual hospital limit specified under B: In-Hospital Benefits;	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs").

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	Practitioners, Psychiatrists and Psychologists.		• Sub-limit of R23 523 per Beneficiary per annum, less the Beneficiary's usage of the sub-limit of R13 272 per family per annum under C19: Mental Health; • Further, shared sub-limit with C19: Mental Health of R2 879 per family per annum for services by Educational and Industrial Psychologists; and • Limit of one (1) individual	• Subject to Private hospital pre-authorisation and managed care protocols and processes. • Subject to use of facility as per B1. • Maximum of three (3) days hospitalisation by a Family Practitioner.

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			psychologist consultation and one (1) group psychologist consultation per day.	
B19	**Alternatives to Hospitalisation** 1. Sub-acute Hospitals, Physical Rehabilitation Private Nursing and Intravenous (IV) Therapy. 2. Hospice	1. 100% of Scheme Rate, subject to PMBs. 2. 100% of cost, but subject to PMB legislation.	1. Subject to annual hospital limit specified under B: In-Hospital Benefits. 2. Unlimited, but subject to PMB legislation.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to pre-authorisation of alternative facility and services, and managed care protocols and processes. • Includes home nursing, but subject to managed

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				care protocols and processes. • Excludes Frail Care and recuperative holidays. • Refer to Annexure E (Exclusions and Limitations) of GEMS Rules.
B20	**Medical Technologists**	100% of Scheme Rate, subject to PMBs.	Subject to annual hospital limit specified under B: In-Hospital Benefits, and sub-limit of R29 213 per family per annum.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to Private hospital pre-authorisation, case management, and use of facility as per B1. • Includes materials.

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B21	**Breast Reductions**	No benefit.	No benefit, unless PMB.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs").
B22	**Allied Health Services:** Limited to Chiropractors, Homeopaths, Phytotherapists, Acupuncturists and Chinese Medicine Practitioners.	100% of Scheme Rate, subject to PMBs.	Subject to: • Annual hospital limit specified under B: In-Hospital Benefits; and • Sub-limit of R4 255 per family, and R2 830 per Beneficiary, per annum; all of which limits are shared between B22: Allied Health Services and B23:	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to referral by a Family Practitioner or Specialist, managed care protocols and processes, and use of facility as per B1 (subject to the service(s) being related to the admission diagnosis).

REGISTERED BY ME ON
Mondi Govuzela
Signed by: Mondi Govuzela
M.Govuzela@medicalschemes.co.za
02/12/2025 21:29:17(UTC+02:00)
2025/11/28
SIGNIFLOW
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			Other Professional Health Services.	
B23	**Other Professional Health Services** Including Dieticians, Podiatrists, Social Workers, Registered Counsellors and Orthoptists.	100% of Scheme Rate, subject to PMBs.	Shared limits as per B22: Allied Health Services; and Further sub-limit of R2 046 per family per annum for Social Workers and Registered Counsellors.	• All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). • Subject to referral by a Family Practitioner or Specialist, managed care protocols and processes, and use of facility as per B1 (subject to the service(s) being related to the admission diagnosis).
B24	**Alcohol and Drug Dependencies**	100% of cost, but subject to PMB legislation.	Limited to PMBs.	• All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”).

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				• Subject to pre-authorisation of DSP facility, managed care protocols and processes, and use of DSP facility as per Annexure G (Prescribed Minimum Benefits) of GEMS Rules.
C	**OUT-OF-HOSPITAL BENEFITS**			
C1	**Family Practitioner Services** Consultations, visits and all other Family Practitioner services not specifically provided for otherwise in this Annexure.			• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs").

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	1. DSP/Network providers.	1. 100% of Scheme Rate.	1. Unlimited.	1. Benefit includes consultations, visits and approved minor procedures at DSP/Network providers, subject to medical necessity and managed care protocols and processes. Consultations: Sixteenth (16th) and subsequent consultations per Beneficiary per annum, subject to pre-authorization.

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	2. Voluntary use of non-DSP / Out-of-Network providers.	2. 70% of Scheme Rate (30% Member co-payment).	2. Limited to three (3) visits per family per annum and R1 445 per event.	2. Member must pay the claim and submit the claim with proof of payment for reimbursement.
	3. Emergency Medical Conditions at DSP/Network providers or registered emergency facility, or involuntary use of non-DSP / Out-of-Network providers for PMBs.	3. 100% of cost, but subject to PMB legislation. Refer to Annexure G (Prescribed Minimum Benefits) of the GEMS Rules. 4. Reimbursement at 200% of Scheme Rate for procedures specified by managed care, done in practitioners'	3. Unlimited for PMBs, but subject to PMB legislation.	3. Treatment for Emergency Medical Condition (as defined in Section 4 of the main body and Annexure G of the GEMS Rules) at DSP/Network provider or registered emergency medical facility. 4. Subject to managed care protocols and processes. Refer to Family Practitioner Guide.

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Mondi Govuzela

Signed by Mondi Govuzela, M.Govuzela@medicalschemes.co.za
02/12/2025 21:30:38(UTC+02:00)

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		rooms instead of in hospital.		
C2	**Screening Services** Including: Cholesterol, Bone Density, Pap Smear, Prostate Specific Antigen, Glaucoma, TB, Syphilis, Chlamydia, Gonorrhoea, Infant Hearing, Childhood Hearing, Childhood Optometry, Glucose, Occult Blood, Thyrotropin (TSH) for Neonatal Hypothyroidism, Mammogram, and other screenings according to evidence-based standard practice.	100% of Scheme Rate.	Paid from Risk. All screenings are limited to one (1) of each per annum, unless otherwise indicated herein.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • All subject to managed care protocols and processes. • Pap Smears include liquid-based cytology and Hr-HPV DNA tests. • Infant Hearing Screening for Child Dependants under the age of one (1) year. • Childhood Hearing Screening for Child

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				Dependants up to and including the age of seven (7) years. • Neonatal Hypothyroidism screening test - TSH (Thyrotropin) - tariff 4507 only. • Includes screening services provided in pharmacies.
C3	**Preventative Care Services** Includes: All Vaccinations; and Dental Sealants.	100% of Scheme Rate.	Paid from Risk. Influenza Vaccinations: Limited to one (1) course per Beneficiary per annum. Pneumococcal Vaccinations: Limited to one (1) course per	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to managed care protocols and processes.

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Mondi Govuzela

2025/11/28

Signed by: Mondi Govuzela, M.Govuzela@medicalschemes.co.za
02/12/2025 21:31:17(UTC+02:00) SIGNIFLOW

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			Beneficiary every five (5) years for Beneficiaries at risk in accordance with managed care protocols. HPV Vaccinations: Limited to one (1) course per female Beneficiary per lifetime. Other Vaccinations: Limited to R950 per Beneficiary per annum. Dental Sealants: Limited to Beneficiaries under 18 years of age, and subject to use of a Network provider.	• Includes preventative care services provided in pharmacies.

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C4	**Specialist Services** Consultations, visits and all other Specialist services not specifically provided for otherwise in this Annexure.	100% of Scheme Rate for non-Network Specialists. 130% of Scheme Rate for Network Specialists. 200% of Scheme Rate for procedures specified by managed care, performed in practitioners' rooms instead of in hospital. 200% of Scheme Rate for cataract procedures, performed by Ophthalmologists in their rooms.	Limited to five (5) consultations or R5 255 per family, and three (3) consultations or R3 505 per Beneficiary, per annum.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to: o DSP/Network Family Practitioner referral; o Pre-authorisation for each visit, procedure or referral; o List of approved services for radiology and pathology; o Treatment plans; and o Managed care protocols and processes.

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C5	**Dental Services**	100% of Scheme Rate, subject to PMBs.		• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs").
	1. Examinations. 2. Preventative Treatment.		1 and 2: Two (2) treatment events per Beneficiary per annum. Dental Sealants: Excluded under B6: Dentistry and C5: Dental Services, but included under C3: Preventative Care Services for Beneficiaries under 18 years of age.	1 and 2: Subject to list of approved services, managed care protocols and processes, and use of Dental DSP/Network.
	3. Conditions with pain and sepsis.		3: Two (2) events per Beneficiary	3, 4, 5, 6, 7, 8, 9 and 10: Subject to list of approved

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
	4. Fillings. 5. Clinically indicated dental services, including extractions. 6. Intra-oral radiography. 7. Extra-oral radiography.		per annum, subject to PMBs. 4: Unlimited at Dental DSP/Network. 5, 6 and 7: One (1) event per Beneficiary per annum, provided that: o Panoramic x-rays are limit of one (1) per Beneficiary every three (3) years; o Bitewing x-rays are limited to four (4) per Beneficiary per annum; and o Cone Beam Computed	services, managed care protocols and processes, and use of Dental DSP/Network. In respect of Conservative and Restorative Dentistry: o Panoramic and Bitewing x-rays included. Dental services classified as conservative, restorative and specialised per tariff code. 4 and 5: Conscious Sedation: Only applicable to Beneficiaries:- ○ up to and including the age of nine (9) years; or ○ with severe trauma, subject to pre-authorisation, managed care protocols and processes.

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			Tomography (CBCT) scans are limited to one (1) per Beneficiary per lifetime for surgical procedures.	
	8. Clinically indicated root canal treatments.		8: Limited to one (1) root canal treatment per Beneficiary per annum, subject to PMBs.	
	9. Emergency non-DSP visit.		9: Emergency Out-of-Network visit, limited to one (1) event per Beneficiary per annum.	
	10. Plastic Dentures.		10: In accordance with the approved Scheme Tariff.	

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
	11. Periodontal Programme		11: Paid from Risk, but limited to Periodontal Programme benefits.	11: Subject to registration on Periodontal Programme, pre-authorisation, managed care protocols and processes, and use of Dental DSP/Network. If not registered on Periodontal Programme, no Periodontal benefit.
	12. Specialised Dentistry.	12: 100% of cost, but subject to PMB legislation.	12: Limited to PMBs. Refer to Annexure E (Exclusions and Limitations) of the GEMS Rules.	12: Refer to Annexure G (Prescribed Minimum Benefits) of the GEMS Rules.
C6	**Prescribed Medication and Injection Material**			• All limits are subject to A: Statutory Prescribed

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				Minimum Benefits ("PMBs"). • Prescribed, administered and dispensed by healthcare professionals, legally entitled to do so. • Subject to Medicine Price List (MPL) and Medicine Exclusion List (MEL). • Subject to Annexure E (Exclusions and Limitations) of GEMS Rules.
	1. Acute Medical Conditions.	1. 100% of Scheme Rate.	1. Unlimited, save for the limit of R738 per family per annum for homeopathic medicine.	1. Subject to the following: • Managed care protocols, formulary and processes. • Prescription by a healthcare professional, legally entitled to do so.

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Mondi Govuzela
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Signed by Mondi Govuzela, M.Govuzela@medicalschemes.co.za
02/12/2025 21:33:06(UTC+02:00)
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			Prescription by a dispensing Family Practitioner, dispensed by a DSP/Network Pharmacy: Limited to three (3) scripts of up to R253 each per Beneficiary per annum.	• Dispensed by a DSP/Network dispensing Family Practitioner or DSP/Network Pharmacy. • A 30% co-payment shall apply for: o voluntary use of Out-of-Formulary medicine; and o voluntary use of a non-DSP / Out-of-Network dispensing Family Practitioner or non-DSP / Out-of-Network pharmacy. • The dispensing fee is as per the contracted Network Pharmacy Rate.

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				• Benefit includes prescribed maternity vitamin supplements.
	2. Chronic Medical Conditions listed in PMB DTP, PMB CDL and Annexure D of the GEMS Rules	2. 100% of Scheme Rate, subject to PMBs.	2. Unlimited for PMB chronic conditions listed in PMB DTP, PMB CDL and Annexure D of the GEMS Rules, but subject to PMB legislation and the following, which exceed PMB level of care: • Continuous Glucose Monitors (CGM) and Insulin Pumps: Subject to:	2. Subject to the following: • Prior application and approval, Formulary, Medicine Price List, managed care protocols and processes, and prescription by a healthcare professional, legally entitled to do so. • Medicine for chronic conditions listed in PMB DTP, PMB CDL and Annexure D of the GEMS Rules, subject to use of Chronic Medicine Pharmacy DSP, as

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			○ Limit of R28 324 per Beneficiary per annum for consumables (excluding devices, which are provided for under C16: Medical and Surgical Appliances and Prostheses); and ○ Limited to type one (1) diabetics aged below nineteen (19) years. Limit of R5 567 per Beneficiary per annum for non-PMB chronic conditions	provided for in Annexure G (Prescribed Minimum Benefits) of the GEMS Rules. • A 30% co-payment shall apply for voluntary use of Out-of-Formulary medicine and voluntary use of a non-Chronic Medicine Pharmacy DSP. • Chronic Medical Conditions listed in PMB DTP, PMB CDL and Annexure D of the GEMS Rules, shall be paid from limit for non-PMB chronic conditions listed in Annexure D of GEMS Rules; and once limit is exhausted, benefit shall

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Mondi Govuzela
2025/11/28
Signed by: Mondi Govuzela, M.Govuzela@medicalschemes.co.za
02/12/2025 21:34:15(UTC+02:00)
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			listed in Annexure D of the GEMS Rules. No benefit for non-PMB chronic conditions not listed in Annexure D of the GEMS Rules.	be unlimited for PMBs, but subject to PMB legislation. However, consumables for Continuous Glucose Monitors (CGM) and Insulin Pumps for type one (1) diabetics aged below nineteen (19) years shall not be paid from the aforementioned limit, but from the consumable limit for Continuous Glucose Monitors (CGM) and Insulin Pumps for type one (1) diabetics aged below nineteen (19) years only.

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Signed by Mondi Govuzela, M.Govuzela@medicalschemes.co.za
02/12/2025 21:34:30(UTC+02:00)

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	3. Self-Medication: Over-the-Counter (OTC) Medicine.	3. 100% of Scheme Rate.	3. Limited to R120 per Beneficiary per event and R334 per Beneficiary per annum.	3. Subject to the following: • Managed care protocols, Formulary and processes. • For minor ailments, dispensed by a Network Pharmacy or Network Family Practitioner. • A 30% co-payment shall apply for voluntary use of Out-of-Formulary medicine or voluntary use of a non-Network Pharmacy or non-Network Family Practitioner. • Only SAHPRA-registered Schedule 0, 1 and 2 medicines payable from the OTC benefit.

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
	4. Female Contraceptives: Oral, insertables, injectables and dermal.	4. 100% of Scheme Rate.	4. Limited to R3 757 per Beneficiary per annum.	4. Subject to managed care protocols, Formulary and processes.
C7	**Basic Radiology** X-rays and soft tissue ultrasound scans.	100% of Scheme Rate.	Unlimited.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to referral by a Family Practitioner or Specialist, and list of approved services specified in the GEMS Radiology Request Form, and managed care protocols and processes. • 2 x 2D ultrasound scans per pregnancy provided for by C21: Maternity. Alternatively, should any

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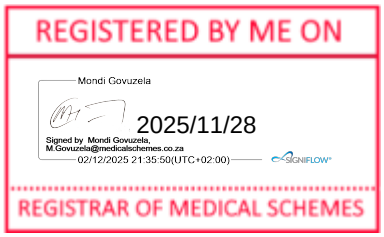
				such 2D scan be substituted with a 3D/4D scan, such 3D/4D scan shall be funded up to the cost of a 2D scan.
C8	**Advanced Radiology**	100% of Scheme Rate, subject to PMBs.	Subject to: • Annual hospital limit specified under B: In-Hospital Benefits; • Sub-limit of R15 183 per Family per annum; and • Further sub-limit of one (1) Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) scan per Beneficiary per annum,	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to Advanced Radiology pre-authorisation, managed care protocols and processes, and use of facility as per B1. • Specific authorisation is required for Angiography, CT scans, MDCT, Coronary Angiography,



NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			all of which limits are shared between B8: Advanced Radiology and C8: Advanced Radiology.	MUGA scans, PET scans, MRI scans and Radio-isotope studies.
C9	**Pathology and Medical Technology**	100% of Scheme Rate.	Unlimited.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to list of approved services, specified in the GEMS Pathology Clinical Request Form. • Pathology pre-authorisation is required for certain tests, as stipulated on the managed

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				care Pathology Clinical Request Form.
C10	**Optical Services** Eye examinations, frames, lenses and contact lenses (permanent or disposable).	100% of Scheme Rate.	Limited to R1 924 per Beneficiary for every two (2) financial years, calculated from 01 January of the year within which any Optical Service was first rendered to the affected Beneficiary following the end of such previous two (2) year period (if any) ended on 31 December ("Financial Cycle"). Limited to: • One (1) eye examination per	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to use of GEMS Optical Network. • Subject to Optical Managed Care protocols and processes. • Optical benefit is not pro-rated, irrespective of date of Beneficiary registration. • Includes tinted lenses, up to a tint of 35%, for albinism and proven

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			Beneficiary per twelve (12) month period, calculated from the month within which same was last rendered to the affected Beneficiary (“Eye Examination Cycle”); and • One (1) frame (subject to the approved list of frames) and one (1) pair of either single vision lenses or bifocal lenses, or 4 x boxes of disposable contact lenses, or	photophobia, subject to pre-authorisation. • Excludes variable tint and photochromic lenses. • Refer to Annexure E (Exclusions and Limitations) of the GEMS Rules for Optometry Exclusions.

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Mondi Govuzela
Signed by Mondi Govuzela
M.Govuzela@medicalschemes.co.za
02/12/2025 21:36:37(UTC+02:00)
2025/11/28
SIGNIFLOW
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			one (1) set of permanent contact lenses, per Beneficiary per twenty-four (24) month period, calculated from the month within which same was last rendered to the affected Beneficiary ("Optical Appliance Cycle"). Either spectacles or contact lenses shall be funded in an Optical Appliance Cycle, not both.	

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			Post-cataract surgery, Optical PMB entitlement shall be limited to the cost of a bifocal lens, not exceeding R1 744 for both lens and frame, with a sublimit of R293 for the frame.	
C11	**Allied Health Services** Limited to Chiropractors, Homeopaths, Phytotherapists, Acupuncturists and Chinese Medicine Practitioners.	100% of Scheme Rate, subject to PMBs.	Limit of R4 255 per family, and R2 830 per Beneficiary, per annum, shared between C11: Allied Health Services, C12: Other Professional Health Services, C13: Physiotherapy, and C14: Audiology, Occupational Therapy and Speech Therapy.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to managed care protocols and processes.

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
C12	**Other Professional Health Services** Including Dieticians, Podiatrists, Social Workers, Registered Counsellors and Orthoptists.	100% of Scheme Rate, subject to PMBs.	Shared limit as per C11: Allied Health Services; and Sub-limit of R2 128 per family per annum for Social Workers and Registered Counsellors.	• All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). • Subject to managed care protocols and processes.
C13	**Physiotherapy**	100% of Scheme Rate, subject to PMBs.	Shared limit as per C11: Allied Health Services.	• All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”). • Subject to managed care protocols and processes.
C14	**Audiology, Occupational Therapy and Speech Therapy**	100% of Scheme Rate, subject to PMBs.	Shared limit as per C11: Allied Health Services.	• All limits are subject to A: Statutory Prescribed Minimum Benefits (“PMBs”).

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				• Subject to managed care protocols and processes.
C15	**Post Hip, Knee and Shoulder Replacement or Revision Physiotherapy**	100% of Scheme Rate.	Limited to 10 post-surgery physiotherapy visits (shared with B12: Post Hip, Knee and Shoulder Replacement or Revision Physiotherapy) up to a limit of R7 044 per Beneficiary per event, utilised within 60 days of surgery.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to hospital pre-authorisation and managed care protocols and processes.
C16	**Medical and Surgical Appliances and Prostheses:** Includes: 1. Hearing Aids; 2. Wheelchairs;	100% of Scheme Rate, subject to PMBs.	All medical and surgical appliances and prostheses (save for Continuous Glucose Monitors (CGM) and	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs").

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Signed by: Mondi Govuzela, M.Govuzela@medicalschemes.co.za
02/12/2025 21:38:00(UTC+02:00) SIGNFLOW

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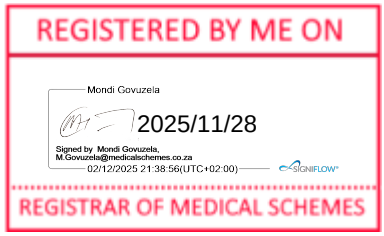
NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
	3. Mobility Scooters; 4. Oxygen Cylinders; 5. Pulse Oximeters; 6. Nebulisers; 7. Positive Airway Pressure (PAP) Devices, i.e. Continuous Positive Airway Pressure (CPAP), Auto-adjusting Positive Airway Pressure (APAP), Bilevel Positive Airway Pressure (BIPAP) and Variable Positive Airway Pressure (VPAP) Devices; 8. Glucometers; 9. Colostomy Kits; 10. Diabetic Equipment; 11. Foot Orthotics; 12. External Prostheses; 13. Compression Stockings;		Insulin Pumps): Subject to: • Annual hospital limit specified under B: In-Hospital Benefits; and • Sub-limit of R14 606 per family per annum, with further, shared sub-limits with B14: Prostheses of: • R6 164 per Beneficiary per annum for foot orthotics and prosthetics, with a sub-limit of R1 761 per Beneficiary per	• Subject to managed care protocols and processes. • Diabetic accessories and appliances, other than Glucometers, Continuous Glucose Monitors (CGM) and Insulin Pumps, to be pre-authorised and claimed from the chronic medication benefit (C6.2). • Foot orthotics and prosthetics, subject to Formulary and managed care protocols and processes. • The Scheme has the right to obtain competitive quotes.

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
	14. Continuous Glucose Monitors (CGM); and 15. Insulin Pumps. Applicable In- and Out-of-Hospital.		annum for orthotic shoes, foot/shoes/ankle inserts and levelers; • R701 for crutches per Beneficiary per annum; • One (1) wheelchair of up to R7 716 per Beneficiary every thirty-six (36) months of month of receipt of wheelchair; • One (1) unilateral hearing aid, or one (1) pair of bilateral hearing aids, of up to R11 223 per hearing aid per Beneficiary	

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			every thirty-six (36) months of month of receipt of hearing aid(s); • One (1) CPAP, APAP, BIPAP or VPAP device (including accessories) of up to R13 328 per Beneficiary every thirty-six (36) months of month of receipt of device; • Three (3) pairs of compression stockings of up to R584 per pair per	



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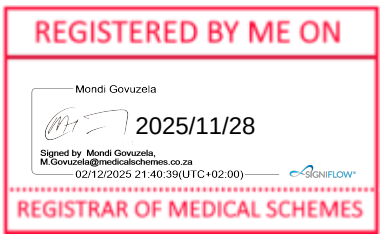
			Beneficiary per annum; • One (1) Pulse Oximeter of up to R467 per family per annum; and • One (1) knee and one (1) back brace of up to R3 499 per brace per Beneficiary per annum. Continuous Glucose Monitors (CGM) and Insulin Pumps: Subject to: • Limit of R59 531 per family per annum for	

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			devices (excluding consumables, which are provided for in the chronic medication benefit (C6.2)); • Sub-limit of one (1) device per Beneficiary every sixty (60) months of month of receipt of device; and • Limited to type one (1) diabetics aged below nineteen (19) years.	

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
C17	**Renal Dialysis** Out-of-Hospital	100% of cost, but subject to PMB legislation.	Limited to PMBs.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to Renal Dialysis pre-authorisation and managed care protocols and processes. • Subject to use of Renal Dialysis Network DSP; failing which, a co-payment of 30% per event shall apply in accordance with Network rules. • Includes materials and related pathology tests.

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				• Once the limit is depleted, the benefit is unlimited for PMBs.
C18	**HIV Infection, Acquired Immune Deficiency Syndrome and Related Illness**	100% of cost, but subject to PMB legislation.	Limited to PMBs.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to managed care protocols and processes. • Pre-exposure prophylaxis included for high-risk Beneficiaries, subject to managed care protocols and processes.
C19	**Mental Health** Consultations, assessments, treatment and counselling by Family Practitioners,	100% of Scheme Rate, subject to PMBs.	Subject to: • Annual hospital limit specified under B: In-Hospital Benefits;	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs").



NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
	Psychiatrists and Psychologists.		• Sub-limit of R13 272 per family per annum, less the sum total of the Beneficiaries' usage of the sub-limit of R23 523 per Beneficiary per annum under B18: Mental Health; • Further, shared sub-limit with B18: Mental Health of R2 879 per family per annum for services by Educational and Industrial Psychologists; and	• Subject to managed care protocols and processes. • Subject to use of a DSP/Network Family Practitioner or DSP/Network Specialist. • If a non-DSP / Out-of-Network Family Practitioner or non-DSP / Out-of-Network Specialist is used, a 30% co-payment shall apply. • If Out-of-Hospital treatment is offered as alternative to hospitalisation, In-Hospital benefits (B1) shall apply.

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
			• Limit of one (1) individual Psychologist consultation and one (1) group Psychologist consultation per day.	
C20	**Infertility**	100% of cost, but subject to PMB legislation.	Limited to PMBs.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to pre-authorisation of facility and service(s), managed care protocols and processes, and use of a DSP (i.e. State or Network) facility; failing

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				which, the Scheme shall not be liable to fund the first R15 000 of the other facility's bill.
C21	**Maternity Programme** Ante- and post-natal care.	100% of Scheme Rate, subject to Maternity Programme Protocols.	Paid from Risk, but limited to Maternity Programme Benefits.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to registration on Maternity Programme, and managed care protocols and processes. • If not registered on Maternity Programme, Out-of-Hospital benefits (excluding this benefit C21: Maternity Programme) shall apply.

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Mondi Govuzela
2025/11/28
Signed by Mondi Govuzela,
M.Govuzela@medicalschemes.co.za
02/12/2025 21:42:07(UTC+02:00)
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				• Includes: o Benefits defined in managed care protocols. o 2 x 2D ultrasound scans per pregnancy. Alternatively, should any such 2D scan be substituted with a 3D/4D scan, such 3D/4D scan shall be funded up to the cost of a 2D scan. o Non-invasive prenatal testing for high-risk pregnancies, subject to pre-authorisation.

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
C22	**Emergency Assistance (Road and Air)**	100% of cost, but subject to PMB legislation.	Unlimited, but subject to PMB legislation.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to use of Emergency Medical Services DSP, and managed care protocols and processes.
C23	**Circumcision**	100% Scheme Rate.	Global fee of R1 994 per Beneficiary per annum. Refer to Annexure E (Exclusions and Limitations) of GEMS Rules.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to pre-authorisation of facility and services, managed care protocols and processes, and use of

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Mondi Govuzela
Signed by: Mondi Govuzela, M.Govuzela@medicalschemes.co.za
02/12/2025 21:43:23(UTC+02:00)
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				DSP/Network Family Practitioner. • Limit applies to: o All related costs, e.g. consultations, medication etc.; and o All post-op care within a month of procedure. • In-Hospital benefits shall apply for circumcisions performed in practitioners' rooms.
C24	**Chronic Back and Neck Rehabilitation Programme**	Negotiated Rate.	Paid from Risk, but limited to Chronic Back and Neck Rehabilitation Programme benefits.	• All limits are subject to A: Statutory Prescribed Minimum Benefits ("PMBs"). • Subject to registration on Chronic Back and Neck

NO	SERVICE / BENEFIT	% BENEFIT / TARIFF	LIMITS / EXCLUSIONS	CONDITIONS / REMARKS
				Rehabilitation Programme, and managed care protocols and processes. • Out-of-Hospital benefits (excluding this benefit C24: Chronic Back and Neck Rehabilitation Programme) shall apply, if not registered on the Chronic Back and Neck Rehabilitation Programme.

Legend:	
Scheme Rate	See Rule 4.36 of the GEMS Rules.
CDL	Chronic Disease List
Chronic DSP	Chronic Designated Service Provider. Subject to Annexure G of the GEMS Rules.
DTP	Diagnosis and Treatment Pairs as provided for in the Regulations to the Medical Schemes Act.
PDF	Professional Dispensing Fee
PMB	Prescribed Minimum Benefit
SEP	Single Exit Price
TTO	Treatment Taken Out

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

Nomzamo Tutu
Nomzamo Tutu (Sep 29, 2025 21:36:29 GMT+2)

Siyabulela Tsengiwe
Siyabulela Tsengiwe (Sep 30, 2025 09:05:17 GMT+2)

Dr Stan Moloabi (Sep 30, 2025 10:01:04 GMT+2)

NT N1 ST ST Dr Stan Moloabi

REGISTERED BY ME ON
Mondi Govuzela
2025/11/28
Signed by: Mondi Govuzela, M.Govuzela@medicalschemes.co.za
02/12/2025 21:44:45(UTC+02:00)
SIGNIFLOW
REGISTRAR OF MEDICAL SCHEMES