SUREMED HEALTH

CHALLENGER OPTION

ANNEXURE A(1)

(With effect from 1 January 2024)

1. Definition of income

”income”, shall mean, for the purpose of calculating contributions in respect of :

1.1 an employee, the employee’s gross monthly salary/pensionable earnings;

1.2 An individual member, his/her gross average monthly earnings from all sources;

1.3 a continuation member in terms of rule 6.2, his/her gross monthly earnings from all sources;

1.4 a member who registers a spouse or partner as a dependant in regard to clause 1.2 and 1.3 above, the higher of member or spouse's or partner's gross monthly earnings, from all sources will be used;

1.5 a member who fails to provide satisfactory and or updated proof of income to the Scheme, the highest income category applicable in terms of this Annexure will apply.

Gross monthly earnings shall be the average for the previous tax year increased by a percentage equal to the CPIX index published by the department of statistics of the Republic of South Africa in respect of the previous calendar year.

2. Basis of contribution payable

2.1 The total contribution payable shall be based on the income and the number of dependants of the member as set out in the table below. Contributions in respect of child dependants shall be limited to a maximum of three registered child dependants. No contributions shall be payable in respect of more than three registered child dependants.

MEMBER'S CONTRIBUTION WITH EFFECT FROM 1 JANUARY 2024

Principal Member	**Adult Dependant* (See Note 1 below)**	**Child Dependant* (See Note 2 below)**
R	R	R
R6 245	R4 655	R1 230

*Note 1: Excluding full-time registered students up to age 25 at a registered tertiary education institution.

*Note 2: Including full-time registered students up to age 25 at a registered tertiary education institution.

3. Time for payment of contributions

All contributions shall be payable monthly in arrears to the account of the Scheme at such place as stipulated and agreed to by the Scheme. All contributions shall be paid to the Scheme within 3 days of the end of the due month and shall be accompanied by the required membership return form fully detailed in respect of changes to membership and contributions.

The Scheme may require an individual member to provide a bank debit order authority for the purposes of collecting contributions.

4. Premium penalties for persons joining late in life

4.1 The Scheme may apply premium penalties to a late joiner and such penalties must be applied only to the portion of the contribution related to the member or any adult dependant who qualifies for late joiner penalties.

Late joiner penalties are only applicable to members and adult dependants over the age of 35.

4.2 The premium penalties referred to in paragraph 4.1 shall not exceed the following bands:

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

4.3 To determine the applicable penalty band to be applied to a late joiner in terms of the first column of the table in paragraph 4.2 the following formula shall be applied:

A = B minus (35+C)

where

“A” means the number of years referred to in the first column of the table in paragraph 4.2 for purposes of determining the appropriate penalty band;

“B” means the age of the late joiner at the time of his or her application for membership or admission as a dependant; and

“C” means the number of years of creditable coverage which can be demonstrated by the late joiner.

4.4 Where an applicant or his or her dependant produces evidence of creditable coverage after a late joiner penalty has been imposed, the Scheme must recalculate the penalty and apply such revised penalty from the time such evidence is provided.

4.5 Late joiner penalties may continue to be applied upon transfer of the member or adult dependant to other medical schemes.

6. Waiting periods

See Annexure D.

ooooo00000ooooo

SUREMED HEALTH

CHALLENGER OPTION

ANNEXURE B(1)

BENEFITS

Effective 1 January 2024
(unless otherwise stated below)

A ENTITLEMENT TO BENEFITS

Beneficiaries are entitled to the prescribed minimum benefits and the annual benefits stipulated in paragraph C this Annexure.
Entitlement to benefits is subject to the main rules, Annexures C and D, and paragraphs B and C of this Annexure.

B OVERALL ANNUAL LIMIT AND CHARGING OF BENEFITS

B1 Charging of benefits: Benefits shall be charged to the major medical risk pool up to the limits set out in the column headed “MONETARY OR OTHER LIMITS.” On depletion of those limits the member shall be liable for payment of the claim. Subject to PMB’s.

		MONETARY OR OTHER LIMITS
C	**ANNUAL BENEFITS**	
C1.	**ALTERNATIVE HEALTH CARE SERVICES**	
	Homeopathy	
	Consultations and medicines	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the national health reference price list (NHRPL) for services provided by practitioners registered in terms of the relevant South African law.	Combined limit with Paramedical Services
C2.	**AMBULANCE SERVICES**	
	100% of the cost if approved by the preferred provider.	Subject to overall annual limit if preferred provider is used or if preferred provider authorizes alternative provider

SUREMED
CHALLENGER OPTION
ANNEXURE B(1)

		MONETARY OR OTHER LIMITS
C3.	**APPLIANCES (EXTERNAL ACCESSORIES)**	
C3.1	**In hospital**	
	Subject to the relevant managed health care programme and clinical protocols **[Amended with effect from 1 January 2013]**:	
	100% of the cost of general medical and surgical appliances. Subject to pre-authorisation **[Amended with effect from 1 January 2014]**	R9 300 per member family. **[Amended with effect from 1 January 2019]**
	Hearing aid(s) once every 3 years, limited to R5 000 CPAP machine once every 3 years, limited to R5 000 Nebulisers / Humidifiers limited to R500 Glucometers once every 3 years, limited to R500 Back support limited to R2 500 Orthotics limited to R1 000 **[Amended with effect from 1 January 2013]**	
C3.2	**Out of hospital**	
	Subject to the relevant managed health care programme:	
C3.2.1	100% of the cost of disposable materials used to treat diabetes.	Limited to and included in C3.1

Appliances (continued)		**MONETARY OR OTHER LIMITS**
C3.2.2	100% of the cost of oxygen, cylinders, concentrators, home ventilators and attachments including **[Amended with effect from 1 January 2013]** CPAP machines.	R6000 per member family **[Amended with effect from 1 January 2020]**
C3.2.3	100% of the cost of all other medical and surgical appliances.	Limited to and included in C3.1
C3.2.4	100% of the cost of hearing aids and wheelchairs.	Limited to and included in C3.1
C4.	**BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS**	
C4.1	100% of the cost of blood and blood products.	
C4.2	Subject to the relevant managed health care programme: 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]**.	

C5.	**CONSULTATIONS AND VISITS**	**MONETARY OR OTHER LIMITS**
	This paragraph expressly excludes consultations and visits to dental practitioners and therapists (see paragraph C6), in-hospital psychiatrists and psychologists (see paragraph C12), oncologists (see paragraph C14), social workers (see paragraph C17), physiotherapists (see paragraph C19), and services provided in respect of ante-natal visits and post-natal visits (see paragraph C10), organ and tissue transplants (see paragraph C16) and renal dialysis (see paragraph C23).	
C5.1	**In hospital**	
	Subject to the relevant managed health care programme: 150% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for consultations and visits by medical specialists and general practitioners.	

Consultations and visits (continued)		**MONETARY OR OTHER LIMITS**
C5.2	**Out of hospital**	
C5.2.1	**General practitioners**	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for consultations and visits by general practitioners in the supplier's rooms or patient's home or primary health care facility.	R5 500 per beneficiary and R15 000 per member family **[Amended with effect from 1 January 2023]**
C5.2.2	**Medical specialists**	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for consultations and visits by medical specialists in the supplier's rooms or patient's home or primary health care facility.	Limited to and included in C5.2.1

MONETARY OR OTHER LIMITS

C6. DENTISTRY

Subject to the relevant managed health care programme:

C6.1 Basic

C6.1.1 Dental practitioners

100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for basic dentistry.

C6.1.2 Dental therapists

100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for basic dentistry performed by dental therapists.

Dentistry (continued)	**MONETARY OR OTHER LIMITS**
C6.2 Advanced	
100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for inlays, crowns, bridges, mounted study models, plastic or metal base partial dentures, the treatment by periodontists (excluding oral medical and periodontal plastic procedures), maxilla-facial surgery and prosthodontists and the dental technicians' fees for all such dentistry **[Amended with effect from 1 January 2013]**.	R6 960 per beneficiary to a maximum of R15 852 per member family. **[Amended with effect from 1 January 2020)**
C6.3 Osseo-integrated implants and orthognathic surgery (functional correction of malocclusions)	
100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for all services rendered including the cost of special investigations, hospitalization, all general and specialist dental practitioners and their respective assistants and anaesthetist as well as the cost of materials, including all implant components, plates, screws and bone and bone equivalents.	

Dentistry (continued)		**MONETARY OR OTHER LIMITS**
	This benefit includes all stages of treatment required to achieve the end result of placing an implant-supported tooth or supported teeth into spaces left by previous removal of natural teeth. This includes the surgical augmentation of jawbone and surgical placement and exposure of implants.	Limited to and included in C6.2
C6.4	**Oral surgery**	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff. Benefit for general anaesthetic and hospitalisation for conservative dental work excluded except in the case of trauma, patients under the age of 12 years and impacted 3rd molars. Benefit limit includes all hospital and doctor cost. **[Amended with effect from 1 January 2013].**	R13 820 PMF **[Amended with effect from 1 January 2020]**
C6.5	**Maxillo-facial surgery**	
	See paragraph C6.2 **[Amended with effect from 1 January 2013]**	See paragraph C24.3
C6.6	**Orthodontic treatment**	
	Subject to pre-authorisation: 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]**.	Limited to and included in C6.2

C7. HOSPITALISATION

This paragraph expressly excludes the benefit for hospitalization arising out of osseo-integrated implants and orthognathic surgery (see paragraph C6.3), maternity (see paragraph C10.1) mental health (see paragraph C12.1), organ and tissue transplants (see paragraph C16) and refractive surgery (see paragraph C24.2).

Authorisation shall be obtained from the organisation that provides the Schemes Hospital Benefit Management programme before a beneficiary is admitted to a hospital or day clinic (except in the case of emergency and PMB's) failing which a levy of R1000 per admission shall apply.

In the event of an emergency the organisation that provides the Schemes Hospital Benefit Management programme must be notified of such emergency within one working day after admission failing which a R1000 levy shall apply.

[Amended w.e.f. 1 January 2008]

C7.1 Private hospitals: Providers other than preferred providers

C7.1.1 Accommodation

100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or NHRPL for accommodation in a general ward, high care ward and intensive care unit.

C7.1.2 Operating theatre

100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or NHRPL for theatre fees.

Hospitalisation (continued)		**MONETARY OR OTHER LIMITS**
C7.1.3	**Medicine, material and hospital apparatus** 100% of the cost of disinfectants, medicine, injection material, anaesthetics, bandages, intravenous feeding and other material prescribed and used, including the cost of procedures and the use of hospital apparatus and the transport of blood.	
C7.1.4	**Medicine on discharge (TTO's)** Medicine given to a patient to take home are subject to paragraph C11 and limited to R500 per beneficiary per event. **[Amended w.e.f. 1 January 2008]**	R500 per beneficiary per event included in C11.1.1 (routine medication).
C7.1.5	**Casualty / emergency room visits**	
C7.1.5.1	Medicines given to a patient to take home (TTO's) are subject to paragraph C11 and limited to R500 per beneficiary per event. **[Amended w.e.f. 1 January 2008]**	R500 per beneficiary per event included in C11.1.1 (routine medication).
C7.1.5.2	Consultations and visits charged by a general practitioner or medical specialist	Limited to and included in C5.2
C7.1.5.3	Facility / ambulatory hospital fee: No benefit.	R500 per member family per case.

[Amended w.e.f. 1 January 2016]

Hospitalisation (continued)		**MONETARY OR OTHER LIMITS**
C7.2	**Private hospitals: preferred providers**	
C7.2.1	**Accommodation**	
	100% of the negotiated fee	
C.7.2.2	**Operating theatre**	
	100% of the negotiated fee for theatre costs, including the fee for using the theatre after hours and for the use of registered unattached theatres.	
C7.2.3	**Medicine, material and hospital apparatus**	
	100% of the negotiated fee for disinfectants, medicine, injection material, anaesthetics, bandages, intravenous feeding and other material prescribed and used, including the cost of procedures and the use of hospital apparatus and the transport of blood.	
C7.2.4	**Medicine on discharge (TTO's)**	
	Medicine given to a patient to take home are subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event included in C11.1.1 (routine medication).

Hospitalisation (continued)		**MONETARY OR OTHER LIMITS**
C7.2.5	**Casualty / emergency room visits**	
C7.2.5.1	Medicines given to a patient to take home (TTO's) are subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event included in C11.1.1 (routine medication).
C7.2.5.2	Consultations and visits charged by a general practitioner or medical specialist	Limited to and included in C5.2
C7.2.5.3	Facility / ambulatory hospital fee.	R500 per member family per case. **[Amended w.e.f. 1 January 2016]**
C7.3	**Public hospitals**	
C7.3.1	**Accommodation**	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL	
C7.3.2	**Operating theatre**	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for theatre costs, including the fee for using the theatre after hours and for the use of registered unattached theatres.	

Hospitalisation (continued)		**MONETARY OR OTHER LIMITS**
C7.3.3	**Medicine, material and hospital apparatus** 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for disinfectants, medicine, injection material, anaesthetics, bandages, intravenous feeding and other material prescribed and used, including the cost of procedures and the use of hospital apparatus and the transport of blood.	
C7.3.4	**Medicine on discharge (TTO's)** Medicines given to a patient to take home are subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event included in C11.1.1 (routine medication).
C7.3.5	**Casualty / emergency room visits**	
C7.3.5.1	Medicines given to a patient to take home (TTO's) are subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event included in C11.1.1 (routine medication).
C7.3.5.2	Consultations and visits charged by a general practitioner or medical specialist	Limited to and included in C5.2
C7.3.5.3	Facility / ambulatory hospital fee	R500 per member family per case. **[Amended w.e.f. 1 January 2016]**

Hospitalisation (continued)		**MONETARY OR OTHER LIMITS**
C7.4	**Secondary facilities**	
C7.4.1	**Sub-acute facilities, hospice and rehabilitation facilities**	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for all services rendered by sub-acute facilities, hospice and rehabilitation facilities. Excluding all services for the rehabilitation for substance abuse.	R20 000 PMF **[Amended with effect from 1 January 2014]**
C7.4.2	**Nursing services and private nurse practitioners, including psychiatric nursing but excluding midwife services**	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for nursing services and private nurse practitioners, including psychiatric nursing but excluding midwife services.	Subject to limit C7.4.1 **[Amended with effect from 1 January 2013]**
C7.5	Compassionate Care Benefit. Limited to R20 000PMF unless a Prescribed Minimum Benefit (PMB). Subject to authorization. **[Amended with effect from 1 January 2018]**	Limited to R20 000PMF **[Added with effect from 1 January 2014]**

		MONETARY OR OTHER LIMITS
C8.	**IMMUNE DEFICIENCY RELATED TO HIV INFECTION**	
	Subject to the relevant managed health care programme:	
C8.1	**Anti-retroviral medicines**	
	100% of the base price as determined from time to time in terms of the relevant managed health care programme, plus a fixed dispensing fee per line item or per prescription where applicable, less the negotiated discount.	Subject to Overall Annual Limit and PMB's
C8.2	**Related medicines**	
	In respect of legally prescribed medicines and injection materials:	Subject to Overall Annual Limit and PMB's
	100% of the reference price or negotiated price.	
C8.3	Benefits for all other services shall be subject to the benefits applicable in paragraphs C1 to C24.	Limits as per paragraphs C1 to C23

		MONETARY OR OTHER LIMITS
C9.	**INFERTILITY**	
	Subject to the relevant managed health care programme:	
	No benefit in the private sector.	Subject to PMB's
C10.	**MATERNITY**	
	Subject to the relevant managed health care programme:	
C10.1	**Confinement In hospital**	
C10.1.1	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for accommodation, theatre fees, labour ward fees, drugs, dressings, materials and equipment. Caesarean section must be provided as being clinically necessary to qualify for full payment. Non-clinically necessary caesarean sections would result in the confinement benefit being limited to the amount available for vaginal deliveries in accordance with the scheme approved tariff.	
C10.1.2	In respect of legally prescribed medicines and administration devices:	
	100% of the reference price or negotiated price. Medicines given to a patient to take home shall be limited to a maximum of R500 per beneficiary per event.	

Maternity (continued)		**MONETARY OR OTHER LIMITS**
C10.1.3	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for the delivery by a midwife, general practitioner or medical specialist, including the attendant anaesthetist and paediatrician.	
C10.2	**Confinement out of hospital**	
C10.2.1	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for the delivery by a general practitioner, medical specialist or midwife.	
C10.2.2	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for services at a registered birthing unit.	

Maternity (continued)		**MONETARY OR OTHER LIMITS**
C10.3	**Related services**	
C10.3.1	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for pregnancy related tests and two 2D pregnancy scans during a normal pregnancy by a general practitioner, medical specialist or midwife.	
C10.3.2	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for registered medicines, dressings and materials supplied by a midwife.	Limited to and included in C11.1.1
C10.3.3	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for nine ante-natal consultations with a general practitioner, medical specialist or midwife.	
C10.3.4	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for post-natal care by a general practitioner, medical specialist or midwife up to and including the one post-natal consultation for normal confinements.	

Maternity (continued)		**MONETARY OR OTHER LIMITS**
C10.3.5	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for one amniocentesis by a general practitioner or medical specialist.	
C10.3.6	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for ante-natal classes.	Limited to R500 per member family
C10.3.7	100% of the lower of the reference price or the negotiated price in respect of the costs of immunisation for the child.	
C10.3.8	The benefits in respect of C10.3 are subject to registration and compliance with the relevant maternity programme within the prescribed time limit.	
C10.3.9	Maternity benefit paid at 100% of scheme tariff limited to 2 2D scans, 2 gynae/GP visits, one Paediatrician visit and Antenatal Vitamins: R65 per month for 9months payable from Acute Benefit. Subject to registration on the maternity programme. **[Added with effect from 1 January 2020]**	

C10.4 Termination of pregnancy

100% of the negotiated fee or, 100% of cost for accommodation, theatre fees, labour ward fees, drugs, dressings, medicines and materials in a private or State hospital and for drugs, dressings, medicines and materials used.	Subject to PMB's

	MONETARY OR OTHER LIMITS

C11. MEDICINES AND INJECTION MATERIAL

This paragraph expressly excludes medicines in respect of alternative health care services, (see paragraph C1), in-hospital medicines (see paragraph C7.1.4), anti-retroviral drugs (see paragraphs C8.1 and C8.2), oncology (see paragraph C14.2) and organ and tissue transplants (see paragraph C16.3).

C11.1 Routine medication

Subject to the relevant managed health care programme:

C11.1.1	In respect of legally prescribed routine medication, excluding homeopathic medicines 100% of the lower of the reference price or the negotiated price. This paragraph excludes prescriptions supplied for use in a hospital but includes a maximum of R500 per beneficiary per event for in-patients on discharge from hospital.	R7 055 per beneficiary and R22 500 per member family. A 20% levy per beneficiary is imposed once the benefit utilisation of R3 900 per beneficiary is reached. **[Amended with effect from 1 January 2023]**

Medicines and injection materials (continued)		**MONETARY OR OTHER LIMITS**
C11.1.2	**Pharmacy advised therapy** In respect of Schedules 0, 1 and 2 medicines advised and dispensed by a pharmacist: 100% of the lower of the reference price or negotiated price.	Limited to 1 script per member family per month to a max of a R170 per script with an annual sub-limit of a R1 630 included in C11.1.1 **[Amended with effect from 1 January 2020]**

C11.2	**Extended medication**	
	Subject to the relevant managed health care programme:	
C11.2 1	In respect of legally prescribed extended medication for the conditions referred to in paragraph 7.9.2 of Annexure D and the following conditions: Ankylosing spondylitis, Scleroderma, Dermatomyositis, Huntington's disease, Major depression, Myasthenia gravis Narcolepsy, Obsessive compulsive disorder, Organ transplantation, Paget's disease, Psoriasis, Osteoporosis & Severe Osteopenia with risk factors and Psychoses; 100% of the cost.	
C12.	**MENTAL HEALTH**	**MONETARY OR OTHER LIMITS**
C12.1	**In hospital**	
C12.1.1	Subject to authorisation from the relevant managed health care programme.	R 19 200 per member family. Inclusive of all costs (Hospital and attending providers) **[Amended with effect from 1 January 2019].**

C12.1.2	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for accommodation in a general ward.	
C12.1.3	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for electro-convulsive treatment fees.	Limited to and included in C12.1.1
C12.1.4	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for materials and hospital equipment.	Limited to and included in C12.1.1
C12.1.5	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for consultations and visits.	Limited to and included in C12.1.1

Mental health (continued)		**MONETARY OR OTHER LIMITS**
C12.1. 6	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for procedures prescribed by general practitioners, psychiatrists or psychologists.	Limited to and included in C12.1.1

C12.1.7	In respect of legally prescribed medicines and injection material: 100% of the lower of the reference price or negotiated price.	Limited to and included in C12.1.1
C12.1.8	**Medicines given to a patient to take home (TTO's)** Subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event included in C11.1.1 (routine medication).

Mental health (continued)		**MONETARY OR OTHER LIMITS**
C12.2	**Out of hospital**	
C12.2.1	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]**for consultations and visits.	Limited to and included in C5.2.1

C12.2.2	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for consultations by general practitioners, psychiatrists or psychologists at the supplier's rooms or in any facility or at any place other than a registered hospital.	Limited to and included in C5.2.1 or C17.1 **[Amended with effect from 1 January 2013]**
C12.2.3	In respect of legally prescribed medicines and injection materials: 100% of the lower of the reference price or negotiated price.	Limited to and included in C11.1.1
C12.3	**Rehabilitation for substance abuse**	
	100% of the lower of cost or the negotiated fee	R2 000 per member family for all services, subject to prior approval.

MONETARY OR OTHER LIMITS

C13. NON-SURGICAL PROCEDURES AND TESTS

This paragraph expressly excludes psychiatry and psychology (see paragraphs C12.1.5 and C12.2.2), radiology (see paragraph C21) and optometric examinations by registered optometrists or supplementary optical practitioners (see paragraph C15.4).

C13.1 In hospital

Subject to the relevant managed health care programme:

C13.1.1 General practitioner and clinical technologist

100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for all non-surgical procedures performed by a general practitioner or clinical technologist.

C13.1.2 Medical specialist

100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for all non-surgical procedures performed by a medical specialist.

Non-surgical procedures and tests (continued)		**MONETARY OR OTHER LIMITS**
C13.2	**Out of hospital (including treatment in practitioners' rooms)**	
C13.2.1	**General practitioner and clinical technologist** 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for all non-surgical procedures performed by a general practitioner or clinical technologist.	
C13.2.2	**Medical specialist** 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for all non-surgical procedures performed by a medical specialist.	
C14.	**ONCOLOGY** Subject to the relevant managed health care programme and PMB's	PMB's Unlimited through Preferred Provider
C14.1	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for oncologist consultations, visits, treatment and materials for radiotherapy and chemotherapy during the active treatment period.	Limited to R300 000 per member family. **[Amended with effect from 1 January 2018]**

C14.2	In respect of legally prescribed medicine and injection material used in chemotherapy: 100% of the reference price or negotiated price.	Limited to and included in C14.1
C14.3	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for all services performed by a pathologist and radiologist during the active treatment period. Any radiology and pathology must be pre-authorised for benefits.	Limited to and included in C14.1
C15.	**OPTOMETRY**	
	Subject to the relevant managed health care programme. Benefit for spectacles or contact lenses. **[Amended with effect from 1 January 2013]**	
C15.1	**Frames**	
	100% of the tariff. Benefit every two years. **[Amended with effect from 1 January 2014]**	R1 150 per beneficiary. Included in C15.2.1. **[Amended with effect from 1 January 2018]**
C15.2	**Spectacle lenses**	
	100% of the tariff. Benefit every two years. **[Amended with effect from 1 January 2013]**	
C15.2.1	**Single vision, bifocal and multifocal lenses and Readers**	

Optometry (continued)		MONETARY OR OTHER LIMITS
	100% of the lower of the cost or Suremed Scheme tariff limited to clear, single vision, bifocal or multifocals or one pair of Readers in place of single vision reading lenses. **[Amended with effect from 1 January 2014]**	R2 250 per beneficiary and R6 300 per member family. Limited to either C15.2 or C15.3. **[Amended with effect from 1 January 2023]**
C15.2.2	**Lens additions**	
	100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]**.	Limited to and included in C15.2.1
C15.2.3	**Sunglasses and repairs to frames**	
	No benefit.	No benefit
C15.3	**Contact lenses**	
	100% of the lower of the cost or Suremed Scheme tariff for contact lenses, when prescribed by a registered optometrist, ophthalmologist or supplementary optical practitioner.	Limited to and included in C15.2.1 and to either C15.2 or C15.3.
C15.4	**Optometric examinations**	
	100% of the lower cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]**.	One examination per beneficiary per annum

			MONETARY OR OTHER LIMITS
C16.	**ORGAN AND TISSUE TRANSPLANTS**		
	Subject to the relevant managed health care programme, pre-authorisation and PMB's:		
C16.1	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for harvesting of the organ and transplantation thereof. The benefit does not include the cost incurred by the donor of the organ where the donor is registered on another medical scheme. **[Amended with effect from 1 January 2013]**		R170 000 per member family. **[Amended with effect from 1 January 2017]**
C16.2	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for stem cell harvesting and transplantation limited to allogenic and autologous drafts derived from the South African Bone Marrow Registry. **[Amended with effect from 1 January 2013]**		Limited to and included in C16.1
C16.3	In respect of legally prescribed post-operative anti-rejection medicines: 100% of the lower of the reference price or the negotiated price.		Limited to and included in C16.1

		MONETARY OR OTHER LIMITS
C17.	**PARAMEDICAL SERVICES (ALLIED MEDICAL PROFESSIONS)**	
C17.1	**General services**	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for services in respect of:	R2 250 per beneficiary and R5 700 per member family collectively for all services. **[Amended with effect from 1 January 2019]**
	Audiology Dietetics Genetic counseling Hearing aid acoustics Homeopathy Occupational therapy, Orthoptics Podiatry Speech therapy Social workers Clinical and counseling psychology **[Amended with effect from 1 January 2013]**	

MONETARY OR OTHER LIMITS

C18. PATHOLOGY AND MEDICAL TECHNOLOGY

C18.1 In hospital

Subject to the relevant managed health care programme:

100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for all tests performed by a pathologist or medical technologist. **[Amended with effect from 1 January 2013]**

C18.2 Out of hospital

100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for all tests performed by a pathologist or medical technologist.

			MONETARY OR OTHER LIMITS
C19.	**PHYSICAL THERAPY**		
C19.1	**In hospital**		
	Subject to the relevant managed health care programme:		R6 000per beneficiary. **[Added with effect from 1 January 2021]**
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for physiotherapy, occupational therapy and biokinetics. **[Amended with effect from 1 January 2016].**		
C19.2	**Out of hospital**		
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for physiotherapy, chiropractics (including x-rays) and biokinetics.		Limited to and included in C17.1 **[Amended with effect from 1 January 2013]**

		MONETARY OR OTHER LIMITS
C20.	**PREVENTATIVE CARE AND WELLNESS** Subject to pre-authorisation,100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for the following : mammograms, PAP smears, prostate examinations and tonometry as per standard.	R1 600 per beneficiary to a maximum of R3 210 per member family. **[Amended with effect from 1 January 2023]**
C21.	**PROSTHESES AND DEVICES – INTERNAL**	
	This paragraph expressly excludes internal prosthesis (osseo-integrated implants) for the purpose of replacing a missing tooth or teeth.	
	Subject to the relevant managed health care programme and PMB's :	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for internal prostheses. **[Amended with effect from 1 January 2013]**	R40 000 per beneficiary **[Amended with effect from 1 January 2019]**
	Spinal fusion, limited to 2 levels per year to a maximum of R23 000, Inta Occular lens limited to R2 500 and Mesh limited to R7 000. **[Amended with effect from 1 January 2013]**	

			MONETARY OR OTHER LIMITS
C22	**RADIOLOGY AND RADIOGRAPHY** Subject to the relevant managed health care programme and PMB's:		
22.1	**General radiology**		
C22.1.1	**In hospital**		
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for diagnostic radiology, tests and ultrasounds.		
C22.1.2	**Out of hospital**		
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for diagnostic radiology, tests and ultrasounds.		
C22.2	**Specialised radiology**		
C22.2.1	**In hospital**		
	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for MRI scans, CT scans, Gallium scans and RI studies, subject to obtaining a pre-authorisation additional to any pre-authorisation already obtained for hospitalization.		R18 700 per member family In and Out of hospital **[Amended with effect from 1 January 2019]**

		MONETARY OR OTHER LIMITS
C22.2.2	**Out of hospital**	
	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for MRI scans, CT scans, Gallium scans and RI studies, subject to obtaining a pre-authorisation failing which a 20% co-payment shall apply.	
C23.	**RENAL DIALYSIS (CHRONIC)**	
	Subject to the relevant managed health care programme and PMB's:	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Scheme Rates for consultations, visits, all services, materials and medicines associated with the cost of renal dialysis.	Unlimited per member family. **[Amended with effect from 1 January 2020]**
C24.	**SURGICAL PROCEDURES**	
	This paragraph expressly excludes services provided in respect of osseo-integrated implants and orthognathic surgery (see paragraph C6.3), oral surgery (see paragraph C6.4), maternity (see paragraph C10) and organ and tissue transplants (see paragraph C16).	
	Subject to the relevant managed health care programme:	

Surgical procedures (continued)		MONETARY OR OTHER LIMITS
C24.1	**General**	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for surgical procedures performed by a general practitioner, medical specialist and clinical technologist.	
C24.2	**Refractive surgery**	
	No benefit.	No benefit
C24.3	**Maxillo-facial surgery**	
	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the Suremed Scheme tariff for maxillo-facial surgery.	Limited to and included in C6.2 **[Amended with effect from 1 January 2013]**

oooooOOOOOooooo

SUREMED HEALTH

NAVIGATOR OPTION

ANNEXURE A(2)

(With effect from 1 January 2024)

1. Basis of contribution payable

1.1 The total contribution payable shall be based on the number of dependants of the member as set out in table 1 below including the additional contribution to the savings account the member makes in terms of paragraph 1.2 and table 2 below.

Contributions for child dependants as defined in the rules are only payable up to a maximum of 3 child dependants. All dependants thereafter are free.

1.2 Every member shall pay an additional contribution, based on the number of dependants of the member, in terms of table 2 below and that amount shall be credited to the member's personal medical savings account and shall be dealt with as set out in Annexure E.

TABLE 1

MEMBER’S BASIC CONTRIBUTION WITH EFFECT FROM 1 JANUARY 2024

Principal member	Adult dependant* See Note 1 below	Child dependant* See Note 2 below and paragraph 1.1 above
R	R	R
R3 359	R2 635	R979

***Note 1: “Adult dependant” means a dependant over age 21, excluding full-time registered students up to age 25 at a registered tertiary education institution.**

***Note 2: “Child dependant” means all biological and/or adopted child dependants under the age of 21 and full-time registered students up to age 25 at a registered tertiary education institution.**

TABLE 2

MEMBER'S ADDITIONAL CONTRIBUTION WITH EFFECT FROM 1 JANUARY 2024

Principal member	**Adult dependant* See Note 1 below**	**Child dependant* See Note 2 below and paragraph 1.1 above**
R	R	R
R525	R405	R169

***Note 1: "Adult dependant" means a dependant over age 21, excluding full-time registered students up to age 25 at a registered tertiary education institution.**

***Note 2: "Child dependant" means all biological and/or adopted child dependants under the age of 21 and full-time registered students up to age 25 at a registered tertiary education institution.**

TABLE 3

MEMBER’S TOTAL CONTRIBUTION WITH EFFECT FROM 1 JANUARY 2024

Principal member	**Adult dependant* See Note 1 below**	**Child dependant* See Note 2 below and paragraph 1.1 above**
R	R	R
R3 884	R3 040	R1 148

***Note 1: “Adult dependant” means a dependant over age 21, excluding full-time registered students up to age 25 at a registered tertiary education institution.**

***Note 2: “Child dependant” means all biological and/or adopted child dependants under the age of 21 and full-time registered students up to age 25 at a registered tertiary education institution.**

2. Time for payment of contributions

All contributions shall be payable monthly in arrears to the account of the Scheme at such place as stipulated and agreed to by the Scheme. All contributions shall be paid to the Scheme within 3 days of the end of the due month and shall be accompanied by the required membership return form fully detailed in respect of changes to membership and contributions. The Scheme may require an individual member to provide a bank debit order authority for the purposes of collecting contributions.

3. Premium penalties for persons joining late in life

3.1 The Scheme may apply premium penalties to a late joiner and such penalties must be applied only to the portion of the contribution related to the member or any adult dependant who qualifies for late joiner penalties.

Late joiner penalties are only applicable to members and adult dependants over the age of 35.

3.2 The premium penalties referred to in paragraph 3.1 shall not exceed the following bands:

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

3.3 To determine the applicable penalty band to be applied to a late joiner in terms of the first column of the table in paragraph 3.2 the following formula shall be applied:

A = B minus (35+C)

where

"A" means the number of years referred to in the first column of the table in paragraph 3.2 for purposes of determining the appropriate penalty band;

"B" means the age of the late joiner at the time of his or her application for membership or admission as a dependant; and

"C" means the number of years of creditable coverage which can be demonstrated by the late joiner.

3.4 Where an applicant or his or her dependant produces evidence of creditable coverage after a late joiner penalty has been imposed, the Scheme must recalculate the penalty and apply such revised penalty from the time such evidence is provided.

3.5 Late joiner penalties may continue to be applied upon transfer of the member or adult dependant to other medical schemes.

4. Waiting periods

See Annexure D.

ooooo00000ooooo

SUREMED HEALTH

NAVIGATOR OPTION

ANNEXURE B(2)

BENEFITS

Effective 1 January 2024
(unless otherwise stated below)

A ENTITLEMENT TO BENEFITS

Beneficiaries are entitled to the prescribed minimum benefits and the annual benefits stipulated in paragraph C this Annexure.

Entitlement to benefits is subject to the main rules, Annexures C and D, and paragraphs B and C of this Annexure.

B ANNUAL LIMITS AND CHARGING OF BENEFITS. Subject to PMB's.

B1 There is an overall annual limit of R13 090 per beneficiary **[Amended with effect from 1 January 2024]**, to a maximum of R25 680 per member family **[Amended with effect from 1 January 2024]** in respect of benefits referred to in C1 (auxiliary) C3.1 (external appliances), C5.2 (out-of-hospital general practitioner and specialist consultations and visits), C6 (dentistry), C7.1.4 (non-preferred private hospital TTO medicines), C7.1.5 (non preferred private hospitals casualty/emergency room visits), C7.2.4(preferred private hospital TTO medicines), C7.2.5 (preferred private hospitals casualty/emergency room visits), C7.3.4 (public hospital TTO medicines), C7.3.5.1 (casualty / emergency room visits), C11.1 (routine medication), C12.1.8 (mental health TTO medicines), C12.2 (mental health out-of-hospital), C12.3 (rehabilitation for substance abuse), C13.2 (out-of-hospital non-surgical procedures and tests), C15 (Optometry), C18.2 (out-of-hospital pathology), C19.2 (out-of-hospital physical therapy), C20 (preventative care and wellness), C22.1.2 (out-of-hospital general radiology). All inner limits referred to in the columns in paragraph C below are included in and accumulate to this overall annual limit. Where no inner limit is stated, the benefit shall be subject to this overall annual limit.

B2 Charging of benefits: Benefits reflected in paragraph B1 of this Annexure shall be charged in terms of paragraph 2.3.1 of Annexure E. All benefits shall be subject to "MONETARY OR OTHER LIMITS" where applicable, irrespective of whether benefits payable from MSA or major medical risk pool **[Amended with effect from 1 January 2013]**

C ANNUAL BENEFITS

C1. ALTERNATIVE HEALTH CARE SERVICES

Auxiliary **[Amended with effect from 1 January 2013]**

Consultations and medicines

100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for practices registered in terms of the relevant South African law.

C2. AMBULANCE SERVICES

100% of the cost if approved by the preferred provider.

MONETARY OR OTHER LIMITS

C3. APPLIANCES (EXTERNAL ACCESSORIES)

C3.1 In and out of hospital

Subject to the relevant managed health care program and clinical protocol: **[Amended with effect from 1 January 2013]**

100% of the cost of general medical and surgical appliances including wheel chairs and hearing aids.	R2 500 per member family. **[Amended with effect from 1 January 2019]**

Hearing aid(s) 3 per cycle, limited to R5 000
CPAP machine 3 per cycle, limited to R5 000
Nebulisers / Humidifiers limited to R500
Glucometers 3 per cycle, limited to R500
Back support limited to R2 500
Orthotics limited to R1 000
[Amended with effect from 1 January 2013]

C4. BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS

C4.1 100% of the cost of blood and blood products.

C4.2 Subject to the relevant managed health care programme and PMB's :

100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for blood equivalents.

C5.	**CONSULTATIONS AND VISITS**	**MONETARY OR OTHER LIMITS**

This paragraph expressly excludes consultations and visits to dental practitioners and therapists (see paragraph C6), in-hospital psychiatrists and psychologists (see paragraph C12), oncologists (see paragraph C14), social workers (see paragraph C17), physiotherapists (see paragraph C19), and services provided in respect of ante-natal visits and post-natal visits (see paragraph C10), organ and tissue transplants (see paragraph C16) and renal dialysis (see paragraph C23).

C5.1 In hospital

Subject to the relevant managed health care programme: 125% **[Amended with effect from 1 January 2015]** of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for consultations and visits by medical specialists and general practitioners.

Consultations and visits (continued) | **MONETARY OR OTHER LIMITS**

C5.2 Out of hospital

C5.2.1 General practitioners

100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for consultations and visits by general practitioners in the supplier's rooms or patient's home or primary health care facility.

C5.2.2 Medical specialists

100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for consultations and visits by medical specialists in the supplier's rooms or patient's home or primary health care facility.

MONETARY OR OTHER LIMITS

C6. DENTISTRY

Subject to the relevant managed health care programme:

C6.1 Basic

C6.1.1 Dental practitioners

100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff for basic dentistry **[Amended with effect from 1 January 2013]**

C6.1.2 Dental therapists

100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for basic dentistry performed by dental therapists.

Dentistry (continued)		**MONETARY OR OTHER LIMITS**
C6.2	**Advanced**	
	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff for inlays, crowns, bridges, mounted study models, plastic or **[Amended with effect from 1 January 2013]** metal base dentures every three year **[Amended with effect from 1 January 2013]**, the treatment by periodontists (excluding oral medical and periodontal plastic procedures) and prosthodontists and the dental technicians' fees for all such dentistry.	R4 800 per beneficiary **[Amended with effect from 1 January 2020]**
C6.3	**Osseo-integrated implants and orthognathic surgery (functional correction of malocclusions)**	
	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff for all services rendered including the cost of special investigations, all general and specialist dental practitioners and their respective assistants and anesthetists as well as the cost of materials, including all implant components, plates, screws and bone and bone equivalents.	

Dentistry (continued)		**MONETARY OR OTHER LIMITS**
	This benefit includes all stages of treatment required to achieve the end result of placing an implant-supported tooth or supported teeth into spaces left by previous removal of natural teeth. This includes the surgical augmentation of jawbone and surgical placement and exposure of implants.	Limited to and included in C6.2
C6.4	**Oral surgery**	
	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff. Benefit for general anaesthetic and hospitalisation for conservative dental work excluded except in the case of trauma, patients under the age of 12 years and impacted 3rd molars. Benefit limit includes all hospital and doctor cost. **[Amended with effect from 1 January 2013]**	R10 700 PMF **[Amended with effect from 1 January 2020]**
C6.5	**Maxillo-facial surgery**	
	See paragraph C24.3	See paragraph C24.3
C6.6	**Orthodontic treatment**	
	Subject to pre-authorisation:	
	100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]**.	Limited to and included in C6.2

MONETARY OR OTHER LIMITS

C7. HOSPITALISATION

This paragraph expressly excludes the benefit for hospitalisation arising out of osseo-integrated implants and orthognathic surgery (see paragraph C6.3), maternity (see paragraph C10.1) mental health (see paragraph C12.1), organ and tissue transplants (see paragraph C16) and refractive surgery (see paragraph C24.2).

Authorisation shall be obtained from the organisation that provides the Schemes Hospital Benefit Management programme before a beneficiary is admitted to a hospital or day clinic (except in the case of emergency) failing which a levy of R1000 per admission shall apply. Except PMB's.
In the event of an emergency the organisation that provides the Schemes Hospital Benefit Management programme must be notified of such emergency within one working day after admission failing which a R1000 levy shall apply.

C7.1 Private hospitals: Providers other than preferred providers

C7.1.1 Accommodation

100% of the lower of the cost, NHRPL or negotiated fee for accommodation in a general ward, high care ward and intensive care unit.

C7.1.2 Operating theatre

100% of the lower of the cost or NHRPL for theatre fees.

Hospitalisation (continued)		**MONETARY OR OTHER LIMITS**
C7.1.3	**Medicine, material and hospital apparatus**	
	100% of the cost of disinfectants, medicine, injection material, anesthetics, bandages, intravenous feeding and other material prescribed and used, including the cost of procedures and the use of hospital apparatus and the transport of blood.	
C7.1.4	**Medicine on discharge (TTO's)**	
	Medicine given to a patient to take home are subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event.
C7.1.5	**Casualty / emergency room visits**	
C7.1.5.1	Medicines given to a patient to take home (TTO's) are subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event.
C7.1.5.2	Consultations and visits charged by a general practitioner or medical specialist.	
C7.1.5.3	Facility / ambulatory hospital fee: no benefit.	No benefit

Hospitalisation (continued) | **MONETARY OR OTHER LIMITS**

C7.2 Private hospitals: preferred providers

C7.2.1 Accommodation

100% of the negotiated fee

C.7.2.2 Operating theatre

100% of the negotiated fee for theatre costs, including the fee for using the theatre after hours and for the use of registered unattached theatres.

C7.2.3 Medicine, material and hospital apparatus

100% of the negotiated fee for disinfectants, medicine, injection material, anesthetics, bandages, intravenous feeding and other material prescribed and used, including the cost of procedures and the use of hospital apparatus and the transport of blood.

C7.2.4 Medicine on discharge (TTO's)

Medicine given to a patient to take home are subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event

Hospitalisation (continued)		**MONETARY OR OTHER LIMITS**
C7.2.5	**Casualty / emergency room visits**	
C7.2.5.1	Medicines given to a patient to take home (TTO's) are subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event.
C7.2.5.2	Consultations and visits charged by a general practitioner or medical specialist	
C7.2.5.3	Facility / ambulatory hospital fee: no benefit	No benefit
C7.3	**Public hospitals**	
C7.3.1	**Accommodation** 100% of the lower of the cost or NHRPL	
C7.3.2	**Operating theatre** 100% of the lower of the cost or NHRPL for theatre costs, including the fee for using the theatre after hours and for the use of registered unattached theatres.	

Hospitalisation (continued)		**MONETARY OR OTHER LIMITS**
C7.3.3	**Medicine, material and hospital apparatus**	
	100% of the lower of the cost or the NHRPL for disinfectants, medicine, injection material, anesthetics, bandages, intravenous feeding and other material prescribed and used, including the cost of procedures and the use of hospital apparatus and the transport of blood.	
C7.3.4	**Medicine on discharge (TTO's)**	
	Medicines given to a patient to take home are subject to paragraph C11 and limited to R500 per beneficiary per event. **[Amended w.e.f. 1 January 2008]**	R500 per beneficiary per event.
C7.3.5	**Casualty / emergency room visits**	
C7.3.5.1	Medicines given to a patient to take home (TTO's) are subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event.
C7.3.5.2	Consultations and visits charged by a general practitioner or medical specialist.	
C7.3.5.3	Facility / ambulatory hospital fee: no benefit.	No benefit

Hospitalisation (continued)		**MONETARY OR OTHER LIMITS**
C7.4	**Secondary facilities**	
C7.4.1	**Sub-acute facilities, hospice and rehabilitation facilities**	
	100% of the lower of the cost, Scheme rate or negotiated fee for all services rendered by sub-acute facilities, hospice and rehabilitation facilities unless a Prescribed Minimum Benefit (PMB). Excluding all services for the rehabilitation for substance abuse, see **C12.3.** **[Amended with effect from 1 January 2018]**	R20 000 PMF
C7.4.2	**Nursing services and private nurse practitioners, including psychiatric nursing but excluding midwife services**	
	100% of the lower of the cost, Suremed Scheme tariff **[Amended with effect from 1 January 2013]** or negotiated fee for nursing services and private nurse practitioners, including psychiatric nursing but excluding midwife services.	Included and limited to C7.4.1
7.5	Terminal Care Benefit. Limited to palliative care only unless a Prescribed Minimum Benefit (PBM).	Limited to R20 000PMF. Subject to authorization. **[Added with effect from 1 January 2014]**

		MONETARY OR OTHER LIMITS
C8.	**IMMUNE DEFICIENCY RELATED TO HIV INFECTION**	
	Subject to the relevant managed health care programme and PMB's:	
C8.1	**Anti-retroviral medicines**	
	100% of the base price as determined from time to time in terms of the relevant managed health care programme, plus a fixed dispensing fee per line item or per prescription where applicable, less the negotiated discount.	
C8.2	**Related medicines**	
	In respect of legally prescribed medicines and injection materials:	
	100% of the lower of the reference price or negotiated price.	
C8.3	Benefits for all other services shall be subject to the benefits applicable in paragraphs C1 to C23.	Limits as per paragraphs C1 to C23

MONETARY OR OTHER LIMITS

C9. INFERTILITY

Subject to the relevant managed health care programme:

[Amended with effect from 1 January 2018]

Subject to PMB's

C10. MATERNITY

Subject to the relevant managed health care programme:

C10.1 Confinement In hospital

C10.1.1 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Scheme tariff for accommodation, theatre fees, labour ward fees, drugs, dressings, materials and equipment. Caesarean section must be provided as being clinically necessary to qualify for full payment. Non-clinically necessary caesarean sections would result in the confinement benefit being limited to the amount available for vaginal deliveries in accordance with the schemes tariff. **[Amended with effect from 1 January 2018]**

C10.1.2 In respect of legally prescribed medicines and administration devices:

100% of the lower of the reference price or negotiated price.

Medicines given to a patient to take home shall be limited to a maximum of R500 per beneficiary per event.

Maternity (continued) | **MONETARY OR OTHER LIMITS**

C10.1.3 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Scheme tariff for the delivery by a midwife, general practitioner or medical specialist, including the attendant anaesthetist and paediatrician. **[Amended with effect from 1 January 2018]**

C10.2 Confinement out of hospital

C10.2.1 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Scheme tariff for the delivery by a general practitioner, medical specialist or midwife. **[Amended with effect from 1 January 2018]**

C10.2.2 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Scheme tariff for services at a registered birthing unit. **[Amended with effect from 1 January 2018]**

C10.3. Maternity benefit paid at 100% of scheme tariff limited to 2 2D scans, 2 gynae/GP visits, one Paediatrician visit and Antenatal vitmains: R65 per month for 9 months payable from acute benefit. Subject to registration on the maternity programme. **[Added with effect from 1 January 2020]**

Maternity (continued) | **MONETARY OR OTHER LIMITS**

C10.3 Related services

C10.3.1 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for pregnancy related tests and two 2D pregnancy scans during a normal pregnancy by a general practitioner, medical specialist or midwife.

C10.3.2 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for registered medicines, dressings and materials supplied by a midwife.

C10.3.3 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for nine ante-natal consultations with a general practitioner, medical specialist or midwife.

C10.3.4 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the scheme tariff for post-natal care by a general practitioner, medical specialist or midwife up to and including the one post-natal consultation for normal confinements.

Maternity (continued)		**MONETARY OR OTHER LIMITS**
C10.3.5	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for one amniocentesis by a general practitioner or medical specialist.	
C10.3.6	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for ante-natal classes.	Limited to R370 per member family included in C10.
C10.3.7	The benefits in respect of C10.3 are subject to registration and compliance with the relevant maternity programme within the prescribed time limit.	
C10.3.8	100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the scheme in respect of the costs of hospitalisation for the child.	
C10.4	**Termination of pregnancy**	
	100% of the negotiated fee or 100% of cost for accommodation, theatre fees, labour ward fees, drugs, dressings, medicines and materials in a private or State hospital and for drugs, dressings, medicines and materials used.	Subject to PMB's

C11. MEDICINES AND INJECTION MATERIAL

This paragraph expressly excludes medicines in respect of alternative health care services, (see paragraph C1), in-hospital medicines (see paragraph C7.1.4), anti-retroviral drugs (see paragraphs C8.1 and C8.2), oncology (see paragraph C14.2) and organ and tissue transplants (see paragraph C16.3) and

C11.1 Routine medication

Subject to the relevant managed health care programme:

C11.1.1	In respect of legally prescribed routine medication excluding homeopathic medicines: 100% of the lower of the reference price or the negotiated price. This paragraph excludes prescriptions supplied for use in a hospital but includes a maximum of R500 per beneficiary per event for in-patients on discharge from hospital.	R3 165 per beneficiary. For PAT see C11.1.2 **[Amended with effect from 1 January 2020]**

Medicines and injection materials (continued)		**MONETARY OR OTHER LIMITS**
C11.1.2	**Pharmacy advised therapy**	
	In respect of Schedules 0, 1 and 2 medicines advised and dispensed by a pharmacist: 100% of the lower of the reference price or negotiated price.	Limited to 1 script per member family per month to a max of a R160 per script with an annual sub-limit of a R1 425, included in C11.1.1. **[Amended with effect from 1 January 2020]**
C11.2	**Extended medication**	
	Subject to the relevant managed health care programme:	
C11.2 1	In respect of legally prescribed extended medication: 100% of the formulary price.	

C12.	**MENTAL HEALTH**	**MONETARY OR OTHER LIMITS**
C12.1	**In hospital**	
C12.1.1	Subject to authorisation from the relevant managed health care programme. Subject to Prescribed Minimum Benefits (PMB's). **[Amended with effect from 1 January 2018]**	
C12.1.2	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for accommodation in a general ward.	R16 000 per member family **[Amended with effect from 1 January 2019]**
C12.1.3	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for electro-convulsive treatment fees.	Limited to and included in C12.1.1
C12.1.4	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for materials and hospital equipment.	Limited to and included in C12.1.1
C12.1.5	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for consultations and visits.	Limited to and included in C12.1.1

Mental health (continued)		**MONETARY OR OTHER LIMITS**
C12.1. 6	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for procedures prescribed by general practitioners, psychiatrists or psychologists.	Limited to and included in C12.1.1
C12.1.7	In respect of legally prescribed medicines and injection material:	Limited to and included in C12.1.1
	100% of the lower of the reference price or negotiated price.	
C12.1.8	**Medicines given to a patient to take home (TTO's)**	
	Subject to paragraph C11 and limited to R500 per beneficiary per event.	R500 per beneficiary per event.

Mental health (continued) **MONETARY OR OTHER LIMITS**

C12.2 Out of hospital

C12.2.1 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for consultations and visits.

C12.2.2 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for procedures by general practitioners, psychiatrists or psychologists at the supplier's rooms or in any facility or at any place other than a registered hospital.

C12.2.3 In respect of legally prescribed medicines and injection materials:

100% of the lower of the reference price or negotiated price.

C12.3 Rehabilitation for substance abuse

100% of the lower of cost or the negotiated fee
[Amended with effect from 1 January 2018]

MONETARY OR OTHER LIMITS

C13. NON-SURGICAL PROCEDURES AND TESTS

This paragraph expressly excludes psychiatry and psychology (see paragraphs C12.1.5 and C12.2.2), radiology (see paragraph C21) and optometric examinations by registered optometrists or supplementary optical practitioners (see paragraph C15.4).

C13.1 In hospital

Subject to the relevant managed health care programme:

C13.1.1 General practitioner and clinical technologist

100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for all non-surgical procedures performed by a general practitioner or clinical technologist.

C13.1.2 Medical specialist

100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for all non-surgical procedures performed by a medical specialist.

Non-surgical procedures and tests (continued)		**MONETARY OR OTHER LIMITS**
C13.2	**Out of hospital (including treatment in practitioners' rooms)**	
C13.2.1	**General practitioner and clinical technologist**	
	100% of the lower of the cost or scheme tariff for all non-surgical procedures performed by a general practitioner or clinical technologist.	
C13.2.2	**Medical specialist**	
	100% of the lower of the cost or scheme tariff for all non-surgical procedures performed by a medical specialist.	
C14.	**ONCOLOGY**	PMB's Unlimited through Preferred Provider
	Subject to the relevant managed health care programme and PMB's	
14.1	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for oncologist consultations, visits, treatment and materials for radiotherapy and chemotherapy during the active treatment period.	Limited to R250 000 per family**[Amended with effect from 1 January 2018]**

Oncology (continued)		**MONETARY OR OTHER LIMITS**
C14.2	In respect of legally prescribed medicine and injection material used in chemotherapy: 100% of the lower of the reference price or negotiated price.	Limited to and included in C14.1
C14.3	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for all services performed by a pathologist and radiologist during the active treatment period. Any radiology and pathology must be pre-authorised for benefits.	Limited to and included in C14.1
C15.	**OPTOMETRY** Subject to the relevant managed health care programme. Benefit for spectacles or contact lenses **[Amended with effect from 1 January 2013]**	R1 350 per beneficiary to a maximum of R3 380 per member family. **[Amended with effect from 1 January 2023]**
C15.1	**Frames** 100% of the tariff. Benefit every two years. **[Amended with effect from 1 January 2013]**	Limited to and included in C15.
C15.2	**Spectacle lenses** 100% of the tariff. Benefit every two years. **[Amended with effect from 1 January 2013]**	Limited to and included in C15.
C15.2.1	**Single vision, bifocal and multifocal lenses and Readers**	

Optometry (continued)		**MONETARY OR OTHER LIMITS**
	100% of the lower of the cost or Suremed Scheme tariff, limited to clear, single vision, bifocal or multi focals or one pair of Readers in place of single vision reading lenses. 100% of the tariff. Benefit every two years. **[Amended with effect from 1 January 2013]**	Limited to and included in C15. Limited to either C15.2 or C15.3.
C15.2.2	**Lens additions**	
	100% of the lower of the cost or Suremed Scheme tariff 100% of the tariff. Benefit every two years. **[Amended with effect from 1 January 2013]**.	Limited to and included in C15.
C15.2.3	**Sunglasses and repairs to frames**	
	No benefit.	No benefit
C15.3	**Contact lenses**	
	100% of the lower of the cost or scheme tariff for contact lenses, when prescribed by a registered optometrist, ophthalmologist or supplementary optical practitioner.	Limited to and included in C15. and to either C15.2 or C15.3.
C15.4	**Optometric examinations**	
	100% of the lower cost or scheme tariff.	One examination per beneficiary per annum. Limited to and included in C15.

		MONETARY OR OTHER LIMITS
C16.	**ORGAN AND TISSUE TRANSPLANTS**	
	Subject to the relevant managed health care programme, pre-authorisation and PMB's:	
C16.1	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for harvesting of the organ and transplantation thereof. **[Amended with effect from 1 January 2018]**	R150 000 per member family **[Amended with effect from 1 January 2019]**
C16.2	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for stem cell harvesting and transplantation limited to allogenic and autologous drafts derived from the South African Bone Marrow Registry. The benefit does not include the cost incurred by the donor of the organ.	Limited to and included in C16.1
C16.3	In respect of legally prescribed post-operative anti-rejection medicines: 100% of the reference price or the negotiated price.	Limited to and included in C16.1

		MONETARY OR OTHER LIMITS
C17.	**PARAMEDICAL SERVICES (ALLIED MEDICAL PROFESSIONS)**	
	No benefit	No benefit
C18.	**PATHOLOGY AND MEDICAL TECHNOLOGY**	
C18.1	**In hospital**	
	Subject to the relevant managed health care programme: 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for all tests performed by a pathologist or medical technologist.	
C18.2	**Out of hospital**	
	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or scheme tariff for all tests performed by a pathologist or medical technologist.	

		MONETARY OR OTHER LIMITS
C19.	**PHYSICAL THERAPY**	
C19.1	**In hospital**	
	Subject to the relevant managed health care programme:	R5 650 per beneficiary unless PMB's apply **[Added with effect from 1 January 2020]**
	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for physiotherapy and biokinetics.	
C19.2	**Out of hospital**	
	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for physiotherapy, chiropractics (including x-rays) and biokinetics.	
C20.	**PREVENTATIVE CARE AND WELLNESS**	
	Subject to pre-authorisation, 100% of the negotiated fee or, in the absence of such fee, 100% of the lower of the cost or the NHRPL for the following : mammograms, PAP smears, prostate examinations and tonometry as per standard.	R1 110 per beneficiary to a maximum of R2 100 per member family. **[Amended with effect from 1 January 2020]**

MONETARY OR OTHER LIMITS

C21. PROSTHESES AND DEVICES – INTERNAL

This paragraph expressly excludes internal prosthesis (osseo-integrated implants) for the purpose of replacing a missing tooth or teeth.

Subject to the relevant managed health care programme:

100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for internal prostheses.	R35 000 per beneficiary **[Amended with effect from 1 January 2019]**

Spinal fusion, limited to 2 levels per year to a maximum of R25 000, Inta Occular lens limited to R2 500 and Mesh limited to R8 000. **[Amended with effect from 1 January 2019]**

C22. RADIOLOGY AND RADIOGRAPHY

Subject to the relevant managed health care programme and PMB's

C22.1 General radiology

C22.1.1 In hospital

100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for diagnostic radiology, tests and ultrasounds.

Radiology and radiography (continued)		**MONETARY OR OTHER LIMITS**
C22.1.2	**Out of hospital** 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for diagnostic radiology, tests and ultrasounds.	
C22.2	**Specialised radiology**	R16 900 per family In and out of hospital **[Amended with effect from 1 January 2020]**
C22.2.1	**In hospital** 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for MRI scans, CT scans, Gallium scans and RI studies, subject to obtaining a pre-authorisation additional to any pre-authorisation already obtained for hospitalisation.	
C22.2.2	**Out of hospital** 100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Suremed Scheme tariff **[Amended with effect from 1 January 2013]** for MRI scans, CT scans, Gallium scans and RI studies, subject to obtaining a pre-authorisation failing which a 20% co-payment shall apply.	

Radiology and radiography (continued)	**MONETARY OR OTHER LIMITS**
C23. RENAL DIALYSIS (CHRONIC)	
Subject to the relevant managed health care programme and PMB's :	
100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or Scheme Rates for consultations, visits, all services, materials and medicines associated with the cost of renal dialysis.	Unlimited per member family **[Amended with effect from 1 January 2020]**
C24. SURGICAL PROCEDURES	
This paragraph expressly excludes services provided in respect of osseo-integrated implants and orthognathic surgery (see paragraph C6.3), oral surgery (see paragraph C6.4), maternity (see paragraph C10) and organ and tissue transplants (see paragraph C16).	
Subject to the relevant managed health care programme:	

Surgical procedures (continued)		**MONETARY OR OTHER LIMITS**
C24.1	**General**	
	100% of the negotiated fee or in the absence of such fee, 100% of the lower of the cost or NHRPL for surgical procedures performed by a general practitioner, medical specialist and clinical technologist.	
C24.2	**Refractive surgery**	
	No benefit.	No benefit
C24.3	**Maxillo-facial surgery**	
	100% of the negotiated fee or in the absence of such fee, 100% of the lower of cost or NHRPL for maxillo-facial surgery.	
C25	**Oxygen**	
	100% of the cost of oxygen and cylinders.	R4000 per member family **[Amended with effect from 1 January 2020]**

oooooOOOOOooooo

SUREMED HEALTH

SHUTTLE OPTION

ANNEXURE A(3)

(With effect from 1 January 2024)

1. Basis of contribution payable

1.1 The total contribution payable shall be based on the number of dependants of the member as set out in table 1 below including the additional contribution to the savings account the member makes in terms of paragraph 1.2 and table 2 below.

1.2 Every member shall pay an additional contribution, based on the number of dependants of the member, in terms of table 2 below and that amount shall be credited to the member's personal medical savings account and shall be dealt with as set out in Annexure E**.**

MEMBER'S TOTAL CONTRIBUTION WITH EFFECT FROM 1 JANUARY 2024

Income Category	**Principal member**	**Adult dependant* See Note 1 below**	**Child dependant* See Note 2 below and paragraph 1.1 above**
R	R	R	R
0-9000	R1 150	R1 150	R613
9001 - 13000	R1 509	R1 150	R613
13001 - 17000	R2 172	R2 172	R1 116
17001 - 30000	R2 314	R2 314	R1 172
30 001+	R2 465	R2 465	R1 263

***Note 1: "Adult dependant" means a dependant over age 21, excluding full-time registered students up to age 25 at a registered tertiary education institution.**

***Note 2: "Child dependant" means all biological and/or adopted child dependants under the age of 21 and full-time registered students up to age 25 at a registered tertiary education institution.**

2. Time for payment of contributions

All contributions shall be payable monthly in arrears to the account of the Scheme at such place as stipulated and agreed to by the Scheme. All contributions shall be paid to the Scheme within 3 days of the end of the due month and shall be accompanied by the required membership return form fully detailed in respect of changes to membership and contributions. The Scheme may require an individual member to provide a bank debit order authority for the purposes of collecting contributions.

3. Premium penalties for persons joining late in life

3.1 The Scheme may apply premium penalties to a late joiner and such penalties must be applied only to the portion of the contribution related to the member or any adult dependant who qualifies for late joiner penalties.

Late joiner penalties are only applicable to members and adult dependants over the age of 35.

3.2 The premium penalties referred to in paragraph 3.1 shall not exceed the following bands:

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

3.3 To determine the applicable penalty band to be applied to a late joiner in terms of the first column of the table in paragraph 3.2 the following formula shall be applied:

A = B minus (35+C)

where

“A” means the number of years referred to in the first column of the table in paragraph 3.2 for purposes of determining the appropriate penalty band;

“B” means the age of the late joiner at the time of his or her application for membership or admission as a dependant; and

“C” means the number of years of creditable coverage which can be demonstrated by the late joiner.

3.4 Where an applicant or his or her dependant produces evidence of creditable coverage after a late joiner penalty has been imposed, the Scheme must recalculate the penalty and apply such revised penalty from the time such evidence is provided.

3.5 Late joiner penalties may continue to be applied upon transfer of the member or adult dependant to other medical schemes.

4. Waiting periods

See Annexure D.

ooooo00000ooooo

ANNEXURE B3 – SHUTTLE OPTION

BENEFITS WITH EFFECT 1 January 2024

SUBJECT TO THE PROVISIONS OF THESE RULES MEMBERS AND THEIR REGISTERED DEPENDANTS ARE ENTITLED TO THE FOLLOWING BENEFITS (UNLESS EXCLUDED AS PROVIDED FOR IN ANNEXURE C)

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
A.	STATUTORY PRESCRIBED MINIMUM BENEFITS	100% of cost	No limit	-Services rendered by Public Hospitals or any Designated Service Provider. - Prime Cure Protocols Apply -All services to be delivered at designated service provider only, alternatively through referral by a Prime Cure DSP/DSPN to a Prime Cure approved non-DSP provider subject to preauthorization of all referrals through the Prime Cure Call Centre **[Amended with effect from 1 January 2020]**
B.	BENEFITS OTHER THAN PRESCRIBED MINIMUM BENEFITS		BENEFIT LIMITS AS DESCRIBED BELOW	

C.	HOSPITALISATION LIMIT 1. Private & public hospitals, registered unattached operating theatres and day clinics: 1.1 Accommodation in a general ward, high care ward and intensive care unit. 1.2 Theatre fees. 1.3 Medicines, materials and hospital equipment. 1.4 Visits by medical practitioners. 1.5 Confinement and midwives. 2. Secondary Facilities: 2.1 All services rendered by sub-acute facilities, hospice and rehabilitation facilities. 2.2 All services rendered by nursing services and private nurse practitioners, including psychiatric nursing but excluding midwife services. No pre-authorisation is needed for a nurse consultation 3. Psychiatric hospitalisation. 4. Maxillo-facial 5. In hospital dental 6. Compassionate Care Benefit **[Amended with effect from 1 January 2018]**	Preferred Provider Network of public and private hospitals appointed or contracted by Kaelo Prime Cure100%	1. Unlimited 2. R12 255 per family and subject to In-hospital overall annual limit. 3. PMB's only. 4. Limited to R17 680 per family 5. Limited to trauma , < 7 years and impacted 3rd molars 6. No Benefit. **[Amended with effect from 1 January 2024]**	Pre-authorization required prior to admission for all non-emergency cases and within ~~24~~ 72 hours of admission for all emergency cases, or the first working day after admission. Where no pre-authorization is obtained for elective admissions by the member (or the provider of services), the member will be liable for a co-payment of R5,000 (five thousand rand) per admission **[Amended with effect from 1 January 2023]** A co-pay of R2000 required if listed procedures are not done in a Day Clinic or Free Standing contracted theatres: Gastroscopes, Colonoscopies, Cystoscopies, Hysteroscopies, Arthroscopies, Sigmoidoscopies, Tonsils and adenoidectomies in children, Grommets, Wisdom teeth **[Amended with effect from 1 January 2020]** ~~A co-pay of R2500 will apply for all laproscopic and arthroscopy surgery performed in hospital (57 & 58 Hospitals)~~ **[Amended with effect from 1 January 2023]** In the event of an emergency, members have access to any private or public hospital for emergency medical care, Once stabilised, the member will be transferred to a DSP/DSPN

				hospital. **[Amended with effect from 1 January 2020]** Prime Cure will cover the cost of a Private ward if required for medical reasons, pre authorisation required **[Amended with effect from 1 January 2023]** Elective Caesarean Section subject to case management and second opinion if required by Prime Cure **[Amended with effect from 1 January 2020]** No in-hospital benefits will be paid except in respect of dental procedures for children aged under 7 years. Impacted 3rd molars, and procedures related to trauma are covered. **[Amended with effect from 1 January 2020]** PMB's only and Subject to pre-authorisation at preferred provider network of private and public hospitals only **[Amended with effect from 1 January 2020]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
D.	OSSEO-INTEGRATED IMPLANTS (Dental implants)	0% **[Amended with effect from 1 January 2013]**	Not applicable **[Amended with effect from 1 January 2013]**	Not applicable **[Amended with effect from 1 January 2013]**
E.	SPECIALIST SERVICES: 1. In-hospital services All services including confinements, surgical procedures and operations, the cost of in-hospital anaesthetics and assistance at surgical procedures and operations performed in-hospital. 2. Out-of-hospital services 2.1 Consultations and visits 2.2 Procedures performed in provider's rooms and all other services, including material supplied for injections, pathology and radiology unless stated otherwise in this annexure.	100% Prime Cure agreed tariff **[Amended with effect from 1 January 2020]**	1. Unlimited. **[Amended with effect from 1 January 2020]** ~~2. 5 x Consultations per family per year, max 3 per beneficiary for non-CDL-PMB conditions~~ **[Amended with effect from 1 January 2023]** 2. Limits for non-PMB visits: R8 000 per family and R4 000 per beneficiary per annum. **[Amended with effect from 1 January 2024]**	- Subject to Prime Cure protocol. - In case of involuntary use of non-DSP specialist for PMB conditions and a 30% co-pay will apply if no pre-authorisation obtained in the case of non - emergencies. - Unlimited consultations for PMB conditions, managed according to Prime Cure Protocol. - 30% (thirty percent co-payment by member on the Prime Cure agreed rate if the members fail to obtain a pre-authorisation for a PMB condition. Pre-Authorisation required for each visit and any other referrals or procedures by provider or member **[Amended with effect from 1 January 2023]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
F.	GENERAL PRACTITIONER and NURSING SERVICES 1. In-hospital services All services including confinements, surgical procedures and operations, the cost of in-hospital anaesthetics and assistance at surgical procedures and operations performed in-hospital. 2. Out-of-hospital services 2.1 Consultations and visits 2.2 Procedures performed in provider's rooms and all other services as per list of approved codes, including material supplied for injections, unless stated otherwise in this annexure.	100% of Prime Cure's Agreed Tariff. **[Amended with effect from 1 January 2020]**	1. Unlimited. **[Amended with effect from 1 January 2020]** 2. Unlimited through preferred provider **[Amended with effect from 1 January 2020]**	- Subject to Prime Cure protocol. - No pre-authorisation is needed for a nurse consultation - Members are required to complete the symptom checker on the member app prior to accessing benefit for non-emergency conditions - The member will then be provided an authorisation for a nurse visit, Over The Counter Pharmacy medication for non-emergencies or a GP consultation - Non PMB's -Failure to complete the symptom checker and obtain an authorisation to the appropriate level of care (Nurse, General Practitioner or Specialist) will result in the member being responsible for a 30% co-payment for the account and all associated accounts, for example, pathology, radiology, acute medication - PMB's -Failure to complete the symptom checker for non-emergencies and obtain an authorisation to the appropriate level of care (Nurse, General Practitioner or Specialist) but visits a nominated GP this will result in the member being responsible for a co-payment of 30% of the account and all associated accounts, for example, pathology, radiology,

				acute medication – except in the case of a medical emergency - All out-of-hospital General Practitioner consultations, including small in-rooms procedures at Prime Cure approved DSP Network providers, provided such consultations are medically indicated and subject to Prime Cure's pre-authorisation procedures. - Members will be required to nominate two (2) General Practitioner from the list of contracted Prime Cure providers - Failure to nominate a General Practitioner from the list of contracted Prime Cure providers, the administration system will nominate the General Practitioners on the member's behalf by allocating the first General Practitioner visited as the first nominated General Practitioner and the second General Practitioner visited as the second nominated General Practitioner. Should a member visit a non-nominated General Practitioner without a pre-authorisation or a non-contracted General Practitioner the claim will be rejected if a non-PMB and a 30% co-payment will be applied for consultations related to a PMB condition. Members may change their nominated General Practitioner on the member application

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
G.	CLINICAL TECHNOLOGISTS 1. For services provided in-hospital. 2. In all other cases other than in-hospital treatment.	1. 100% of Prime Cure AT 2. No Benefit **[Amended with effect from 1 January 2020]**	Subject to In-hospital overall annual limit **[Amended with effect from 1 January 2020]**	
H.	DENTAL SERVICES 1. Conservative dentistry including ordinary fillings, extractions, preventative treatment and fluoride application according to a list of approved codes. 2. Specialised dentistry (including maxillofacial surgery) out of hospital **[Amended with effect from 1 January 2023]** 3. Dentistry emergency visits (out of preferred provider's contracted dental network) according to a list of approved codes **[Amended with effect from 1 January 2013]**	100% Prime Cure Tariffs	1. Unlimited when clinically appropriate, subject to Prime Cure protocols Fluoride treatment only covered for children under 12 years **[Amended with effect from 1 January 2020]** 2. Removal of impacted wisdom teeth only at 100%**[Amended with effect from 1 January 2023]** 3. Emergency pain and sepsis treatment and extractions only, one per beneficiary per year Any additional treatment will be	- Limited to a Prime Cure list of approved dental codes and case management - One consultation for a full mouth examination per beneficiary per annum– subject to list of benefit codes - Preventative treatments – one treatment per beneficiary per annum - Fillings (White or Amalgam according to Prime Cure protocols). Pre-authorisation required for 4/more restorations or 5/more Composite fillings (only anterior covered). - Extractions (Only if clinically necessary). Pre-authorisation required for 5/more extractions **[Amended with effect from 1 January 2020]** 2. Paid at 100% of Kaelo Prime Cure Agreed Rate.

			for the member's own account. **[Amended with effect from 1 January 2023]**	- Limited to one event per beneficiary per year. - Subject to case management - Pre-authorisation is needed before the procedure. 2. Dentures - One set of acrylic dentures per family per 24-month cycle - Benefit applicable to members over the age of 21 only. - According to Kaelo Prime Cure list of approved codes. - A co-payment is payable on all dentures, equal to 20% of the total fees charged by the dentist and laboratory (i.e. professional fee plus dental lab fee). - All co-payments must be collected by the dentist from the patient prior to placing the order. - A receipt must be issued to the member when paying the co-payment. - Prime Cure will reimburse the balance on completion, against an invoice from the dentist, together with a copy of the laboratory's invoice. - Prosthetic and laboratory fees are limited to the T-Codes as indicated in the Government Gazette and authorisation must be obtained from Prime Cure before any lab work is requested. **[Amended with effect from 1 January 2023]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
I.	**PRESCRIBED MEDICATION AND INJECTION MATERIAL:** 1. Acute sickness conditions.	100% Prime Cure agreed tariff **[Amended with effect from 1 January 2020]**	1. Unlimited provided an authorisation is obtained for the referrer of the service. **[Amended with effect from 1 January 2020]**	1. Must be prescribed by the members nominated or allocated contracted General Practitioner Members must register to have their chronic medicine covered by completing a Chronic Medicine Application Form with a nominated Kaelo Prime Cure GP, in accordance with Kaelo Prime Cure Protocol, as amended from time to time. **[Amended with effect from 1 January 2023]** 2. Medication not prescribed by a nominated or allocated General Practitioner if on formulary will incur a 30% co-payment. - Only medication on the Prime Cure acute medicine formulary will be covered. -The medication will be provided as part of the acute consultation (when dispensed by a nominated or allocated dispensing practitioner) or by an a contracted service provider/pharmacy if prescribed by a non-dispensing practitioner -Acute Medication prescribed by a Specialist out-of-hospital is covered 100% of agreed rate if the member was referred by a Prime Cure contracted General Practitioner and an authorisation was obtained for the Specialist visit (Non PMB'S). If no authorization obtained the member will be liable for a 30% co-payment.
	2. Chronic sickness conditions.		2. Subject to scheme list of chronic conditions including PMB's.	
	3. To-Take-out medicines (TTO)		3. Subject to a Prime Cure medicines formulary. Limited to 7 days post hospital supply. **[Amended with effect from 1 January 2020]**	

				- Standard formulary medication is available without co-payment, subject to Drug Utilisation Review and Pharmacy Benefit Management 2. Unlimited Chronic Medication but according to a fixed Prime Cure medication formulary only. - Member must register on the program - Nominated or allocated Contracted Prime Cure General Practitioner to complete the Prime Cure Chronic Application Form and submit to Prime Cure, in accordance with Prime Cure Protocol, as amended from time to time. - Only medication prescribed by a Prime Cure contracted General Practitioner will be covered. - Chronic Medication prescribed by a specialist out-of-hospital will only be covered if the member was referred by a Prime Cure Nominated or allocated contracted General Practitioner and the medication is within the Prime Cure formulary, and such medication is dispensed by a Prime Cure contracted pharmacy, once approved by Prime Cure. 3. Subject to a Prime Cure medicines formulary at a Prime Cure Medical Centre or at a DSP pharmacy or through a Prime Cure contracted dispensing practitioner, subject to all medication being prescribed by a Prime Cure general practitioner or other Prime Cure contracted service provider (DSP/DSPN) only

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
	4. Self -Medication Benefit	100% Prime Cure Agreed Tariff	R480 per beneficiary per annum, Maximum of R160 per event (a maximum of 3 events per beneficiary per annum) **[Amended with effect from 1 January 2024]**	- Limited to the fixed Prime Cure medicine formulary for OTC medicines only. Self-medication items for the treatment of day to day ailments. -Medication dispensed by Prime Cure contracted service provider only **[Amended with effect from 1 January 2020]**
J.	RADIOLOGY 1. Specialised Radiology MRI, CAT and/or GALLIUM SCANS and/or RADIOISOTOPES 2. Basic Radiology	1. Preferred Provider 100% Prime Cure Tariff 2 1. In hospital 100% Prime Cure Tariff 2 2. Out Of Hospital - 100% Prime Cure Agreed Tariff **[Amended with effect from 1 January 2020]**,	1. Specialised Radiology R20 800 per family per annum and R9 800 per beneficiary per annum combined limit for in- and out-of-hospital specialised radiology (including CT and MRI scans) Unless PMB 1.1 Subject to In-hospital annual limit 1.2 Unlimited Subject to Prime Protocols **[Amended with effect from 1 January 2023]** 2. Unlimited, subject to an authorisation being obtained for the referral. **[Amended with effect from 1 January 2020]**	- Subject to pre-authorisation and case management - Unless the CT and/or MRI scan forms part of a PMB diagnosis or care plan for a PMB condition according to Prime cure protocols, the benefit is paid at the lower of agreed DSP tariff or NHRPL fees. **[Amended with effect from 1 January 2023]** - Advanced radiology (e.g. MRI, CAT scans, angiography, etc.) are subject to the ~~in-hospital~~ specialized radiology limit for MRI and CT scans. **[Amended with effect from 1 January 2023]** - 3D scans are paid as for 2D scans Agreed Rate - PET Scans are not covered - **[Amended with effect from 1 January 2020]**

	SERVICE	% BENEFITS	ANNUAL LIMITS	CONDITIONS/ REMARKS
K.	PATHOLOGY and MEDICAL TECHNOLOGY 1. Pathology 2. Medical Technology	1. Prime Cure Preferred Provider - 100% **[Amended with effect from 1 January 2020]**, 2. No Benefit **[Amended with effect from 1 January 2020]**,	- Unlimited. **[Amended with effect from 1 January 2015]**,	- In-hospital pathology is subject to the approved list of tests. - No Benefit for out of hospital Medical Technology - Pre-authorisation is required from Prime Cure's call centre for certain pathology tests. - Pathology tests requested by Specialists are only covered if the member was referred by a Prime Cure contracted service provider and authorization was obtained for the specialist consultation - PMB rules apply **[Amended with effect from 1 January 2020]**
L.	CHEMOTHERAPY and RADIOTHERAPY	Preferred Provider - 100% **[Amended with effect from 1 January 2015]**,	PMB's only **[Amended with effect from 1 January 2020]**	Subject to pre-authorisation and registration on Disease Management programme / Case Management, formulary oncology drugs only, confirmation of PMB diagnosis. DSPN State facility only **[Amended with effect from 1 January 2020]**,

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
M.	RENAL DIALYSIS	100%	PMB's Only **[Amended as from 1 January 2020]**	DSPN State facility only Subject to confirmation of PMB diagnosis, members to register on the Disease Management programmes **[Amended as from 1 January 2020]**
N.	PHYSIOTHERAPY 1. In-hospital 2. Out-of-hospital	1. Preferred Provider - 100% 2.No Benefit **[Amended with effect from 1 January 2015]**	1. Subject to In-hospital overall annual limit . **[Amended with effect from 1 January 2020]** 2. No Benefit . **[Amended with effect from 1 January 2015]** .	DSP only and Subject to confirmation of PMB diagnosis **[Amended as from 1 January 2020]**
O.	CLINICAL PSYCHOLOGY	100% of Agreed tariff **[Amended as from 1 January 2020]**	PMB's Only **[Amended with effect from 1 January 2020]**	Pre-Authorisation required and beneficiary must be referred by their contracted General Practitioner or a specialist where the specialist consultation has been authorised. **[Amended as from 1 January 2020]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
P.	BLOOD TRANSFUSIONS	Preferred Provider - 100% **[Amended with effect from 1 January 2015]**	Unlimited. **[Amended with effect from 1 January 2015]**	Prime Cure Preferred Provider and agreed rate **[Amended with effect from 1 January 2020]**
Q.	AMBULANCE SERVICES and EMERGENCY TRANSPORT SERVICES (Road and Air)	Preferred Provider - 100% **[Amended with effect from 1 January 2015]**	No limit	- Authorisation must be obtained from Prime Cure before use is made of an ambulance service, unless PMB's apply. **[Amended with effect from 1 January 2015]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
R.	AFTER HOURS EMERGENCY CARE: 1. General practitioner consultations and outside preferred provider network or contracted providers consulted after hours 2 Emergency out of preferred provider network visits	1. 100% of Agreed rate**[Amended with effect from 1 January 2015]** 2. 100% of Agreed rate**[[Amended with effect from 1 January 2015]**	1 Limited to 1(one) visit per beneficiary or 2 (two) per family. Limited to R1 230 per event including all services **[Amended as from 1 January 2024]** 2. Unlimited **[Amended with effect from 1 January 2015]**	1 Excluding facility fees. • Authorisation is required via the ***member application*** within 72 hours by member or provider. • At any registered emergency medical facility • Excludes services provided by practitioners who are not registered with Health Professional Council of South Africa (HPCSA)Member maybe required to pay and claim back 2 Unlimited without co-payment provided the episode meets the requirements of the *Prime Cure* definition on an ***emergency medical condition***[1] - means the sudden, and at the time unexpected, onset of a life-threatening health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy. • At any registered emergency medical facility

[1] *Emergency Medical Condition* means the sudden, and at the time unexpected, onset of a life-threatening health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy.

				Authorisation is required via the ***member application*** within 72 hours by member or provider
S.	AUXILIARY SERVICES Speech, Occupational Therapy, Physiotherapy and Psychology	100%. Of agreed rate **[Amended with effect from 1 January 2013]**	Subject to Prime Cure Protocols PMB's only **[Amended with effect from 1 January 2020]**	Benefits are only covered provided: - Must form part of a PMB treatment protocol - Referred by a contracted Prime Cure designated service provider - Pre-authorisation is obtained from the Prime Cure Call Centre - In cases where patients self-refer to providers or fails to obtain an authorisation that provide Additional Benefit Option services, the eligible member will be held liable for 30 % of the account **[Amended with effect from 1 January 2020]**
T.	INTERNAL SURGICAL IMPLANTS	100% **[Added as from 1 January 2013]**	PMB rules apply R30 680PB unless PMB's apply. **[Amended as from 1 January 2023]**	Subject to pre-authorisation, clinical protocols, special motivation, pre-authorisation and case management and to DOH national guidelines. **[Amended as from 1 January 2020]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
U.	OTHER MEDICAL AND SURGICAL APPLIANCES	100% of cost **[Amended with effect from 1 January 2020]**	R4160 per family per annum PMB rules apply **[Amended with effect from 1 January 2023]**	- Combined in and out of hospital limit **Amended with effect from 1 January 2020]**

V.	OPTICAL 1. Eye examinations 2. Spectacles 3. Contact lenses 4. Frames **[Amended with effect from 1 January 2020]**	1. 100% Prime Cure Rates **[Amended with effect from 1 January 2020]**	1. One optometric examination per beneficiary per annum. 2. 1 Pair of spectacles per beneficiary per 24 month period 3. No benefits 4. 1 Frame for spectacles allowed per beneficiary every 24 months **[Amended with effect from 1 January 2020]**	2.Multifocal lenses covered up to a limit of R2 500 per beneficiary every 24 months, inclusive of optometric examination, frame, and pair of lenses. Frames outside of the Prime Cure range up to the value of R800. Any frames selected that are more than this will be paid out of pocket. **[Amended with effect from 1 January 2024]**- Includes a visual evaluation, tonometry screening and a diagnosis. -Includes standard CR39 lenses (High quality clear plastic lenses), Single Vision or Bi-focal lenses (Please refer to Qualifying norms) and Members are not entitled to any monetary value regarding the benefit. -Spectacles are granted if the following norms are met: An unaided visual acuity of worse than 6/9 on the Snellen scale for distance vision and near vision, A refraction requirement exceeding 0,5 dioptre sphere and or 0,5 dioptre cylinder on distance vision and 1,25 dioptre sphere on near vision and For the granting of bi-focals, members have to comply with both the distance vision and near vision qualifying norms for both eyes. Prime Cure will however, in borderline cases, take the functionality of the bi-focals into account. -The choice of frame is specified to be from a quality range of Prime Cure approved range of frames, An excess is payable by the member for any frame not

				from the specified Prime Cure range and Members are not entitled to any monetary value regarding the frame. **[Amended with effect from 1 January 2020]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS

W.	Maternity Benefit	!00% of Agreed rate at preferred provider. **[Amended with effect from 1 January 2020]**	Unlimited subject to Prime Cure protocols **[Amended with effect from 1 January 2019]**	~~- Foetal / Maternal ultrasound scans are limited to 2 (two) scans per pregnancy~~
				~~- Ante natal visited at allocate or nominated General Practitioner~~
				Antenatal consultations
				- You are covered for up to 8 visits at your gynaecologist, GP or midwife up to the Prime Cure rate.
				- Antenatal vitamins are covered up to R115 per month, for a maximum of 9 months. **[Amended with effect from 1 January 2024]**
				
				Ultrasound scans and prenatal screening
				- You are covered for up to two 2D ultrasound scans. 3D and 4D scans are paid up to the rate we pay for 2D scans.
				
				- You have cover for a defined basket of blood tests per pregnancy from the Maternity Programme. These tests include:
				  - To confirm pregnancy (qualitative bHCG)
				  - Glucose
				  - HIV Elisa
				  - Blood cross matching(Rh Antigen)
				  - Blood group (A, B and O antigen)

				- Hepatitis B Delivery - Cover for a normal vaginal delivery or emergency Caesarian section in a Prime Cure Network maternity hospital. Elective Caesarean section subject to case management and second opinion if required by Kaelo Prime Cure. Post-natal consultation - You are covered for one post-birth six-week follow-up consultation with a midwife, GP or gynaecologist post-delivery. **[Amended with effect from 1 January 2023]**
X.	HIV/AIDS out-of-hospital benefit	100% of Agreed rate at contracted providers. **[Amended with effect from 1 January 2020]**	No limit	- Ongoing care plan and anti-retroviral treatment subject to registration on the Prime Cure HIV/AIDS programme and treatment according to an evidence based treatment protocol and medicine formulary - Each eligible member is encouraged to register on the Disease Management Program once diagnosed as HIV positive - Consent to record data on the Prime Cure Disease Management Information System - Voluntary counselling and testing

				- Antiretroviral therapy, prophylactic antibiotics & supplements according to Prime Cure protocol - Treatment support from clinical case managers, including counselling and compliance monitoring. - Pathology and monitoring (incl. CD4, viral load, liver enzymes, cholesterol, glucose, urine tests) according to protocols - Treatment of opportunistic infections, according to Prime Cure formulary. -Available at selected service providers only (Members to contact Prime Cure Call Centre for details) **[Amended with effect from 1 January 2020]**
Y.	ORGAN TRANSPLANTS	100%	No limit **-** PMB rules apply.	-DSPN State facility only -Subject to confirmation of PMB diagnosis, pre-authorisation and registration on Disease Management programme / Case Management -Subject to DOH national guidelines **[Amended with effect from 1 January 2020]**
Z.	Flu Vaccination Benefit **[Amended with effect from 1 January 2023]**	100%	One	One flu vaccination per beneficiary per annum at a Kaelo Prime Cure healthcare provider or pharmacy only.

SUREMED HEALTH

EXPLORER OPTION

ANNEXURE A(4)

(With effect from 1 January 2024)

1. Definition of income

”income”, shall mean, for the purpose of calculating contributions in respect of :

1.1 an employee, the employee’s gross monthly salary/pensionable earnings

1.2 an individual member, his/her gross average monthly earnings from all sources;

1.3 a continuation member in terms of rule 6.2, his/her gross monthly earnings from all sources;

1.4 a member who registers a spouse or partner as a dependant in regard to clause 1.2 and 1.3 above, the higher of member or spouse's or partner's gross monthly earnings, from all sources will be used;

1.5 a member who fails to provide satisfactory and or updated proof of income to the Scheme, the highest income category applicable in terms of this Annexure will apply.

Gross monthly earnings shall be the average for the previous tax year increased by a percentage equal to the CPIX index published by the department of statistics of the Republic of South Africa in respect of the previous calendar year.

2. Basis of contribution payable

2.1 The total contribution payable shall be based on the income and the number of dependants of the member as set out in the table below.

MEMBER'S CONTRIBUTION WITH EFFECT FROM 1 JANUARY 2024

Monthly income	Principal Member	Adult Dependant* (See Note 1 below)	Child Dependant* (See Note 2 below)
R	R	R	R
0 – 500	569	569	569
501 – 8 500	1 405	1 245	649
8 501 – 13 000	1 775	1 570	790
13 001 – 17 000	2 815	2 815	820
17 00 Plus	3 510	3 510	1 090

***Note 1: Excluding full-time registered students up to age 25 at a registered tertiary education institution.**

***Note 2: Including full-time registered students up to age 25 at a registered tertiary education institution.**

3. Time for payment of contributions

All contributions shall be payable monthly in arrears to the account of the Scheme at such place as stipulated and agreed to by the Scheme. All contributions shall be paid to the Scheme within 3 days of the end of the due month and shall be accompanied by the required membership return form fully detailed in respect of changes to membership and contributions.

The Scheme may require an individual member to provide a bank debit order authority for the purposes of collecting contributions.

4. Premium penalties for persons joining late in life

4.1 The Scheme may apply premium penalties to a late joiner and such penalties must be applied only to the portion of the contribution related to the member or any adult dependant who qualifies for late joiner penalties.

Late joiner penalties are only applicable to members and adult dependants over the age of 35.

4.2 The premium penalties referred to in paragraph 4.1 shall not exceed the following bands:

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

4.3 To determine the applicable penalty band to be applied to a late joiner in terms of the first column of the table in paragraph 4.2 the following formula shall be applied:

A = B minus (35+C)

where

"A" means the number of years referred to in the first column of the table in paragraph 4.2 for purposes of determining the appropriate penalty band;

"B" means the age of the late joiner at the time of his or her application for membership or admission as a dependant; and

"C" means the number of years of creditable coverage which can be demonstrated by the late joiner.

4.4 Where an applicant or his or her dependant produces evidence of creditable coverage after a late joiner penalty has been imposed, the Scheme must recalculate the penalty and apply such revised penalty from the time such evidence is provided.

4.5 Late joiner penalties may continue to be applied upon transfer of the member or adult dependant to other medical schemes.

6. Waiting periods

See Annexure D.

ooooo00000ooooo

ANNEXURE B4 – EXPLORER OPTION

BENEFITS WITH EFFECT 1 January 2024

SUBJECT TO THE PROVISIONS OF THESE RULES MEMBERS AND THEIR REGISTERED DEPENDANTS ARE ENTITLED TO THE FOLLOWING BENEFITS (UNLESS EXCLUDED AS PROVIDED FOR IN ANNEXURE C)

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
A.	STATUTORY PRESCRIBED MINIMUM BENEFITS AS PER ANNEXURE D	100% of cost	No limit	Services rendered by Public Hospitals or any Designated Service Provider.
B.	BENEFITS OTHER THAN PRESCRIBED MINIMUM BENEFITS		No overall annual limit	
C. MomTYB	HOSPITALISATION LIMIT 1. Private & public hospitals, registered unattached operating theatres and day clinics: 1.1 Accommodation in a general ward, high care ward and intensive care unit. 1.2 Theatre fees. 1.3 Medicines, materials and hospital equipment. 1.4 Visits by medical practitioners. 1.5 Confinement and midwives. 2. Secondary Facilities: 2.1 All services rendered by sub-acute facilities, hospice and rehabilitation facilities. 2.2 All services rendered by nursing services and private nurse practitioners, including psychiatric nursing but excluding midwife services. 3 Psychiatric hospitalisation.	Preferred Provider - 100% Non-Preferred Provider – 70%, unless PMB's apply. **[Amended with effect from 1 January 2018]**	Unlimited **[Amended with effect from 1 January 2015]** 2. R12 500 PMF limit, unless PMB's apply. 3. PMB's at DSP only. **[Amended with effect from 1 January 2013]**	- Authorisation shall be obtained from the Scheme/Scheme's designated agent before a Beneficiary is admitted to a hospital or day clinic (except in the case of emergency) failing which a co-payment of R500 per admission shall apply. - In the event of an emergency the Scheme shall be notified of such emergency within one working day after admission failing which the co-payment shall apply. - The percentage benefit for Medicines shall be subject to a medication formulary and/or reference price list as defined by the Scheme's designated agent

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
				- In the absence of obtaining authorisation and if the Scheme is of the opinion that either the treatment was not appropriate to the case or that the treatment could have been provided other than in-hospital, then, notwithstanding the provisions regarding this benefit, no benefit shall be paid in respect of such treatment. - Accommodation in an intensive care or high care unit is subject to a maximum period 15 days; hereafter authorisation must be obtained for further accommodation. - Minor procedures and dressings which can be performed appropriately in a General Practitioner or specialist's surgery will not receive any hospitalisation benefit. - No in-hospital benefits will be paid in respect of dental procedures.
MomTYB	4. Compassionate Care Benefit **[Amended with effect from 1 January 2018]**		Limited to R20 000PMF unless a Prescribed Minimum Benefit (PMB) **[Added with effect from 1 January 2014]**	Subject to scheme protocol. Authorisation shall be obtained from the Scheme/Scheme's designated agent prior to the commencement of treatment, failing which no benefit will be paid. Limited to palliative care only. **[Added with effect from 1 January 2014]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
D.	OSSEO-INTEGRATED IMPLANTS (Dental implants)	0%	Not applicable	Not applicable
E. MomTYB MomTYB	SPECIALIST SERVICES: 1. In-hospital services All services including confinements, surgical procedures and operations, the cost of in-hospital anaesthetics and assistance at surgical procedures and operations performed in-hospital. 2. Out-of-hospital services 2.1 Consultations and visits 2.2 Procedures performed in provider's rooms and all other services, including material supplied for injections, unless stated otherwise in this annexure.	1. Preferred Provider - 100% Non-Preferred Provider -70%, unless PMB's apply. **[Amended with effect from 1 January 2018]** 2. Preferred Provider - 100% Non-Preferred Provider - 70%, unless PMB's apply. **[Amended with effect from 1 January 2018]**	1. R20 000 PMF, unless PMB's apply. **[Amended with effect from 1 January 2015]** 2.Limited to R3 400 PB per annum **[Amended with effect from 1 January 2019]**	- To be referred through the primary care Preferred Provider and subject to scheme's protocol unless PMB's apply. - Authorisation shall be obtained from the Scheme or the Scheme's designated agent before specialist services are provided, failing which no benefit will be paid, except for PMB's. - In the event of an emergency the Scheme may provide authorisation retrospectively provided it is notified within one working day after the consultation and/or admission, failing which no benefit will be paid, unless PMB's apply. Penalties and levy may apply as indicated in paragraph C. **[Amended with effect from 1 January 2013]**

	SERVICE	**% BENEFIT**	**ANNUAL LIMITS**	**CONDITIONS/ REMARKS**
F. MomTYB PrimeCure	GENERAL PRACTITIONER and NURSING SERVICES 1. In-hospital services All services including confinements, surgical procedures and operations, the cost of in-hospital anaesthetics and assistance at surgical procedures and operations performed in-hospital. 2. Out-of-hospital services 2.1 Consultations and visits 2.2 Procedures performed in provider's rooms and all other services as per list of approved codes, including material supplied for injections, unless stated otherwise in this annexure. 2.3 Virtual Consultations **[Amended with effect from 1 January 2024]**	1. Preferred Provider - 100% Non-Preferred Provider - 70%, unless PMB's apply. **[Amended with effect from 1 January 2018]** 2. Preferred Provider - 100% Non-Preferred Provider - 80%, unless PMB's apply. **[Amended with effect from 1 January 2021]**	1. Included in hospitalisation limit, unless PMB's apply. 2. 12 Consultations per beneficiary at preferred provider. **[Amended with effect from 1 January 2015]**	1. Subject to scheme protocol. 2. Authorisation after 12th visit for PMB's only. Subject to managed care protocol. **[Amended with effect from 1 January 2015]** 2. Members must nominate one (1) GP in the Prime Cure Network as their primary doctor. •If a member fails to nominate a Prime Cure Network GP, then: -The member will be responsible for a 30% co-payment on the account for Prescribed Minimum Benefit (PMB) conditions -The member will be responsible for the full account for a non-PMB condition. •Members may only see one GP at a time. Pre-authorisation is required from the Prime Cure call centre if a beneficiary would like to change to another GP in the Prime Cure Network. •Beneficiaries may only make two changes to their nominated GP per annum. •If the beneficiary's nominated GP is not available, the member may see any Prime Cure Network GP provided

				the member obtains a pre-authorisation before the consultation. •GP consultation includes minor procedures performed in the doctor's rooms, provided the procedures are medically indicated, subject to Prime Cure protocol and pre-authorisation procedures. •All visits after the 12th consultation per beneficiary per annum must be pre-authorised by the beneficiary or provider. PMB rules apply. •It is the beneficiary's responsibility to ensure that pre-authorisation is obtained. if the provider fails to obtain pre-autorisation on the member's behalf. •If a member fails to obtain an authorisationafter the 12th consultation, but visits a nominated GP, the member will be responsible for: -A 30% co-payment for both PMB and non-PMB conditions, which includes any associated accounts, for example, pathology, radiology or acute medication. •If a member visits a non-nominated GP without a pre-authorisation or a non-Prime Cure Network GP then: -The claim will be rejected if it's a non-PMB -A 30% co-payment will be applied for consultations related to a PMB condition. 2.3 • Administrated through virtual consults through Kaelo Health & Dis-Chem clinics • Unlimited Consults • Member is first assessed by a nurse and then referred to a doctor if required • No pre-authorisation required

				• Benefits accessible during waiting period • If the doctor writes a script for medicine or sends members for x-rays or blood tests during a Waiting Period, this won't be paid for. **[Amended with effect from 1 January 2024]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
G.	CLINICAL TECHNOLOGISTS 1. For services provided in-hospital. 2. In all other cases other than in-hospital treatment.	Preferred Provider - 100% Non-Preferred Provider - 70%, unless PMB's apply. **[Amended with effect from 1 January 2018]**	1. Included in hospitalisation limit, unless PMB's apply. 2. No limit.	Subject to preferred provider protocol.
H. Primecure Primecure	DENTAL SERVICES 1. Conservative dentistry including ordinary fillings, extractions, preventative treatment and fluoride application according to a list of approved codes. 2. Dentures	1-2 **[Amended with effect from 1 January 2018]** Preferred Provider - 100% Non-Preferred Provider - 70%, 3. 0% 4. 100%	1. 1 Consultation PB, Unlimited extractions, 1 preventative treatment PB **[Amended with effect from 1 January 2013]**	- General anaesthetic and hospitalisation for conservative dental work excluded. - Denture benefit applicable to members over the age of 21 only and subject to authorisation. Plastic

Primecure	3. Specialised dentistry 4. Dentistry emergency visits (out of preferred provider's contracted dental network) according to a list of approved codes		2. R4 290PMF – limited to one set PMF per 24-month cycle. **[Amended with effect from 1 January 2024]** 3. Not Applicable 4. Limited to 1 event PB (code 8201)	dentures only. A co-payment of 20% for dentures. **[Amended with effect from 1 January 2015]** - The benefit in respect of the Dentistry emergency visits is restricted to emergency extractions and/or pain and sepsis treatment only. - Subject to preferred provider protocol.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
I. Primecure	**PRESCRIBED MEDICATION AND INJECTION MATERIAL:** 1. Acute sickness conditions.	1. Preferred Provider - 100% Non-Preferred Provider - 70%, unless PMB's apply. **[Amended with effect from 1 January 2018]**	1. No limit.	1.1 Medication to be prescribed by a person legally entitled to prescribe. 1.2 The percentage benefit for Medications shall be subject to the preferred provider's medication formulary and limited to prescriptions by the preferred provider's network of contracted General Practitioners and Dental Practitioners, unless PMB's apply. 2. The Chronic Sickness Condition benefit is subject to the preferred provider's protocols and formulary.
Primecure	2. Chronic sickness conditions.	2. Preferred Provider - 100% Non-Preferred Provider - 0%, except for PMB's	2. Subject to PMB's **[Amended with effect from 1 January 2013]**	3. TTO's are subject to a prescribed formulary and/or reference price lists as defined by the Scheme's designated agent.
MomTYB	3. To-Take-out medicines (TTO)	3. Preferred Provider - 100% Non-PP - 0%, unless PMB's appl	3. R300 per beneficiary per event unless PMB's apply.	

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
Primecure	4. Self -Medication Benefit	Preferred Provider -100% Non-Preferred Provider - 70%**[Amended with effect from 1 January 2018]**	R350 PB limited to a maximum of R112 per event , a max of R425 PMF **[Amended with effect from 1 January 2024]**	The Self Medication Benefit is subject to the preferred provider's self- medication formulary.
J. MomTYB (in hospital MOMTYB – out Prime Cure)	RADIOLOGY 1. Specialised Radiology MRI, CAT and/or GALLIUM SCANS and/or RADIOISOTOPES 2. Basic Radiology	1. Preferred Provider - 100% Non-Preferred Provider - 70%, except for PMB's **[Amended with effect from 1 January 2018]** 2. Preferred Provider - 100% Non-Preferred Provider - 70%, except for PMB's **[Amended with effect from 1 January 2018]**	1. Radiology in-hospital and/or referred by a Specialist unless PMB's apply. Specialised Radiology (MRI/CAT and/or Gallium scans and/or Radio-isotopes) – 2 scans PMF. Services rendered in-hospital subject to hospitalisation limit. **[Amended with effect from 1 January 2013]** 2. Primary care Radiology – Unlimited	- MRI, CAT and/or GALLIUM Scans and/or RADIOISOTOPES must be authorised by the Scheme/Scheme's designated agent, except in emergencies, failing which a co-payment of R500 per scan shall apply. - In the event of an emergency the Scheme shall be notified of such emergency within one working day after admission failing which the R500 co-payment shall apply. - Should pre-authorisation for MRI/CAT and GALLIUM scans and/or RADIOISOTOPES not be obtained and the scans would, under normal circumstances, not have been authorised, no benefit will be paid, unless PMB's apply. - Benefit in respect of basic radiology shall be limited to X-Rays prescribed by the preferred provider in accordance with their list of codes included in their radiology formulary. (Black and white X-Rays and soft tissue ultrasounds only). - Pre-authorisation is required from the preferred provider's call centre in respect of any basic radiology

	SERVICE	% BENEFITS	ANNUAL LIMITS	CONDITIONS/ REMARKS
K. (in hospital MOMTYB – out PrimeCure)	PATHOLOGY and MEDICAL TECHNOLOGY 1. Pathology 2. Medical Technology	1. Preferred Provider - 100% Non-Preferred Provider - 70%, unless PMB's apply. 2. Preferred Provider - 100% Non-Preferred Provider -70%, except for PMB's **[Amended with effect from 1 January 2018]**	- Services rendered in-hospital limited to R21 500 PMF, unless PMB's apply. **[Amended with effect from 1 January 2019]** - Primary care Pathology – Unlimited.	- In-hospital pathology is subject to the approved list of tests as determined between the Scheme and its preferred provider. - Out-of-hospital pathology is limited to tests prescribed by the preferred provider, unless PMB's apply. And subject to the preferred provider's list of approved tests. - Pre-authorisation is required from the preferred provider's call centre for certain pathology tests.
L. MomTYB	CHEMOTHERAPY and RADIOTHERAPY	Preferred Provider - 100% Non-Preferred Provider - 70%, unless PMB's apply. 100%**[Amended with effect from 1 January 2018]**	No Limit **[Amended with effect from 1 January 2013]**	PMB's at DSP only **[Amended with effect from 1 January 2013].** Authorisation shall be obtained from the Scheme/Scheme's designated agent prior to commencement of treatment, failing which no benefit will be paid, unless PMB's apply.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
M. MomTYB	RENAL DIALYSIS	100% **[Amended as from 1 January 2013]**	No limit **[Amended as from 1 January 2013]**	PMB's at DSP subject to regulation 8(3). **[Amended as from 1 January 2013]**
N. MomTYB	PHYSIOTHERAPY 1. In-hospital 2. Out-of-hospital	1. Preferred Provider - 100% Non-Preferred Provider - 70% **[Amended as from 1 January 2018]** 2. 0%	1. Limited to R3 550 PMF, unless PMB's apply. **[Amended as from 1 January 2019]** 2. Not Applicable	Pre- authorised subject to PMB's and scheme protocols. **[Amended as from 1 January 2013]**
O.	CLINICAL PSYCHOLOGY	0%	No limit subject to PMB's only.	

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
P.	AUDIOMETRY	0%	Not Applicable	Not Applicable
Q. MomTYB	BLOOD TRANSFUSIONS	Preferred Provider - 100% Non-Preferred Provider - 70% **[Amended as from 1 January 2018]**	Included in hospitalisation limit, unless PMB's apply**.**	Includes the cost of blood, blood equivalents, blood products and the transport of blood.
R. ER24	AMBULANCE SERVICES and EMERGENCY TRANSPORT SERVICES (Road and Air)	Preferred Provider - 100% Non-Preferred Provider - 70%, unless PMB's apply. **[Amended as from 1 January 2018]**	No limit	- Authorisation must be obtained from the contracted preferred provider before use is made of an ambulance service, unless PMB's apply. - In the event of an emergency the contracted preferred provider shall be notified of such emergency within one working day after the transport is provided, failing which no benefit will be paid.

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
S. PrimeCure	AFTER HOURS EMERGENCY CARE: 1. General practitioner consultations and outside preferred provider network 2 Emergency out of preferred provider network visits	1. 100% **[Amended with effect from 1 January 2015]** 2. 100%	1. R1200 per event **[Amended with effect from 1 January 2024]** including all services and medication limited to 1 visit PB and a maximum of 2 visits PMF, unless PMB's apply. 2. No limit (medical emergencies only)	- Limited to emergencies and after-hours services. - The unlimited emergency out of preferred provider network visits benefit is subject to the final diagnosis meeting the requirements of the preferred provider's definition of a medical emergency. - Member to settle account and submit to preferred provider for reimbursement - Subject to preferred provider protocols.
T. MOMTYB	AUXILIARY SERVICES Podiatrists, Speech Therapists and Occupational Therapists, Audiology, etc. 1.In-hospital 2. Out-of -hospital	1. 100% 2. 0%	1.PMB's only 2. Not applicable	Not Applicable
U. MomTYB	INTERNAL SURGICAL IMPLANTS	100% **[Added as from 1 January 2013]**	No limit. **[Added as from 1 January 2013]**	PMB's only. Authorisation must be obtained from the Scheme's designated agent Subject to scheme protocols.**[Added as from 1 January 2013]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
V. MomTYB	OTHER MEDICAL AND SURGICAL APPLIANCES 1. Back, leg, arm and neck supports 2. Crutches 3. Surgical Footwear (Excluding health footwear) 4. Respiratory Oxygen, diabetic and stoma aids continually essential for the medical treatment of the patient. 5. Medical apparatus continually essential for the medical treatment of the patient.	Preferred Provider – 100% Non-Preferred Provider – 70% unless PMB's apply. **[Amended with effect from 1 January 2018]**	R4 000 PMF, unless PMB's apply. **[Amended with effect from 1 January 2019]**	Subject to pre-authorisation by the Scheme and only allowed if forming part of in-hospital treatment unless PMB's apply.
W. Primecure	OPTICAL 1. Eye examinations 2. Spectacles	Preferred Provider - 100% Non-Preferred Provider - 70%**[Amended with effect from 1 January 2018]**	1. One optometry examination per beneficiary every year. 2. One pair spectacles PB every 2 years.	- This benefit shall be provided in accordance with the Preferred Providers' protocols. - The choice of frame is limited to the preferred provider's range of approved frames. - Frames outside of the Prime Cure range up to the value of R800. Any frames selected. **[Amended with effect from 1 January 2024]**

	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/ REMARKS
X. MomTYB	Pregnancy tests, post- and antenatal care, minor trauma treatment. Maternity Benefit	Preferred Provider - 100% Non-Preferred Provider – 70% unless PMB's apply. **[Amended with effect from 1 January 2018]**	No limit except in respect of ultrasounds which are limited to 2 per pregnancy	Benefit includes sonars at Preferred Provider facilities subject to authorisation, failing which no benefit will be paid, unless PMB's apply. - Subject to registration on maternity programme. Limited to 2 visits (GP or Gynae and 2 2D scans,1 Paediatrician visit and Antenatal vitamins worth R68 per month for 9 months. **[Added with effect from 1 January 2023]**
Y. PrimeCure	HIV/AIDS out-of-hospital benefit	Preferred Provider – 100% Non-Preferred Provider –70% unless PMB's apply. . **[Amended with effect from 1 January 2018]**	No limit	- Benefit subject to compliance with the preferred providers disease management program, unless PMB's apply. - No benefit in respect of lost or destroyed medication.
Z. MomTYB	ORGAN TRANSPLANTS **[Added as from 1 January 2013]**	100% **[Added as from 1 January 2013]**	No limit **[Added as from 1 January 2013]**	PMB's at DSP subject to regulation 8(3). **[Added as from 1 January 2013]**