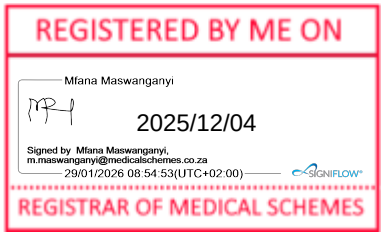
ESSENTIAL OPTION - OVERALL ANNUAL LIMIT (OAL) AND CATEGORY LIMITS:

All limits depicted in this Annexure are annual limits, unless otherwise indicated.

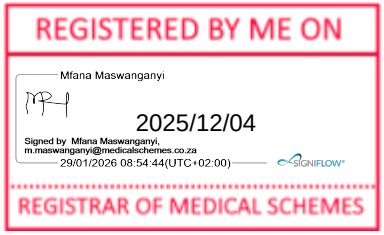
All benefits on the Essential Option are subject to category limits where indicated, and further subject collectively to an Overall Annual Limit (OAL) of R545 290 per family per annum as indicated in 26.2, for all benefits combined.

Continued benefits apply for Prescribed Minimum Benefits (PMBs) after depletion of category limits and/or the OAL, subject to PMB regulations and Annexure E.

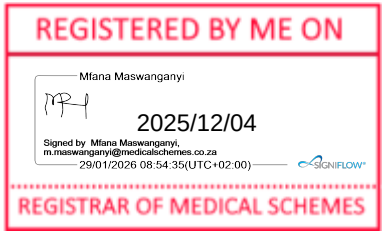
	SERVICE	% BENEFIT	ANNUAL LIMITS	CONDITIONS/REMARKS
1.	**ALCOHOLISM AND DRUG DEPENDENCY**	100% of the lower of cost or recommended tariff for all services	21 days at a SANCA facility or at SANCA rates per beneficiary; PMB benefits subject to Annexure E	Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26 and the PMB regulations
2	**ALTERNATIVE HEALTHCARE SERVICES** Treatment and medicines prescribed or supplied for: • Acupuncture • Naturopathy • Osteopathy	No benefit	No benefit	



3	**AMBULANCE SERVICES** • Transport of a beneficiary by a preferred provider • Transport of a beneficiary by any provider in the case of an emergency	100% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	Subject to the conditions and limits stipulated in paragraph 26, and PMB regulations
4.	**APPLIANCES** Subject to the hospital benefit management programme, prior approval by the Scheme and the conditions and limits stipulated in paragraph 26			
4.1	Medical and surgical appliances, including hearing aids	100% of the cost	R9 402 per family every 3 years	
4.1.1	Hearing aids	100% of the cost	Once every three years, included in medical and surgical appliances limit	
4.1.2	Hearing aid repairs	100% of the cost	R3 932 per beneficiary once every 2 years	
4.2	Home oxygen, cylinders, concentrators and ventilation expenses excluding CPAP machines	100% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	Subject to Annexure E
5	**BLOOD, BLOOD EQUIVALENTS AND BLOOD PRODUCTS**	100% of the cost	Subject to Overall Annual Limit	Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26



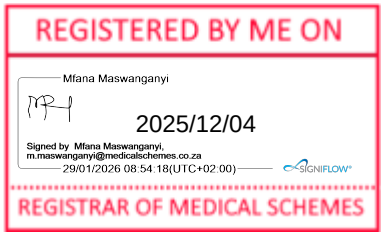
6	**CONSULTATIONS, VISITS AND PROCEDURES** This paragraph expressly excludes services provided in respect of dentistry (see paragraph 7), psychiatry (see paragraph12.2), organ transplants (see paragraph 15), oncology (see paragraph 16) and renal dialysis (see paragraph 21) The Scheme designates the SABMAS Specialist Network as the Designated Service Provider for Specialist treatment in and out of hospital. These Service Providers shall for the purpose of this Annexure be referred to as Designated Service Providers (DSP's). The DSP will be responsible for the provision of all benefits including PMBs. The Scheme nominates the Preferred GP Network for the provision of such GP services as listed below. Member and each dependent have to select a primary and secondary care GP on joining the plan. Member and dependents can elect to change their chosen GP once a year.			
6.1	**In hospital:** Consultations and visits by general practitioners, medical specialists and nurse practitioners in hospital	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26



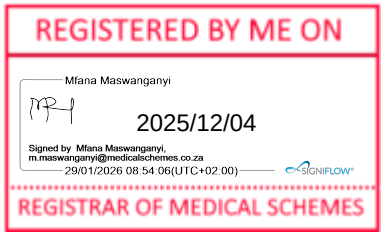
6.2	**Out of hospital:** Consultations and visits by general practitioners, homeopaths, and nurse practitioners in the supplier's rooms or patient's home or primary health care facility	**Where member uses their selected GP:** 100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff **Where member uses GP other than selected GP:** First 3 consultations at 100% of the lower of cost or negotiated fee Fourth consultation onwards at 60% of the lower of cost or negotiated rate	R2 820 per beneficiary for all services combined, including surgical procedures and consumables	Subject to the conditions and limits stipulated in paragraph 26
6.2	**Out of hospital:** Consultations and visits by medical specialists in the supplier's rooms or patient's home or primary health care facility	80% of the negotiated fee where applicable or 80% of the lower of cost or recommended tariff where member is referred by a general practitioner 60% of the negotiated fee where applicable or 60% of the lower of cost or recommended tariff where member is not referred by a general practitioner	R2 747 per beneficiary for all services combined	Subject to the conditions and limits stipulated in paragraph 26

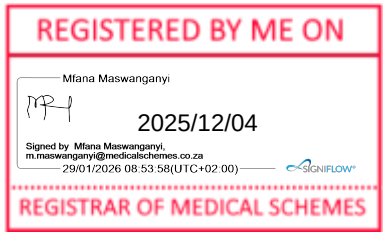
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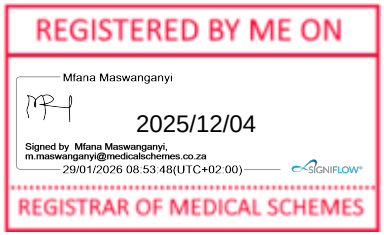
6.3	**Endoscopies**			
6.3.1	**In hospital:** • Colonoscopy • Gastroscopy • Colonoscopy + Gastroscopy • Sigmoidoscopy	90% of the negotiated fee where applicable or 90% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26
6.3.2	**Day hospital:** • Colonoscopy • Gastroscopy • Colonoscopy + Gastroscopy • Sigmoidoscopy	80% of the negotiated fee where applicable or 80% of the lower of cost or recommended tariffs	Subject to Overall Annual Limit	Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26 and PMB regulations
6.3.3	**In Rooms** • Colonoscopy • Gastroscopy • Colonoscopy + Gastroscopy • Sigmoidoscopy	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariffs	Subject to Overall Annual Limit	Subject to the conditions and limits stipulated in paragraph 26 and PMB regulations



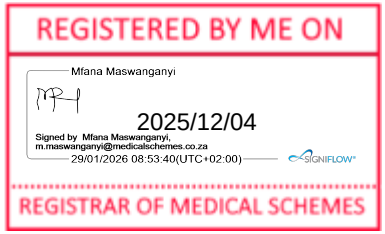
6.4	In-and out-of-hospital management for spinal care and surgery for defined clinically appropriate procedures	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff at a network facility. Network does not apply to any admissions related to trauma. 80% of the negotiated fee where applicable or 80% of the lower of cost or recommended tariff if performed at a non-network facility.	Subject to Overall Annual Limit	Subject to authorisation and the treatment meeting the Scheme's treatment guidelines and clinical criteria. Basket of care as set by the Scheme for out-of-hospital conservative treatment.
6.5	**Circumcisions**	Acute hospitals = 20% co-payment Day Hospital = 10% co-payment of procedure	Subject to Overall Annual Limit	Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26 and PMB regulations
6.6	**Day Clinic Procedures**	Acute hospitals = 20% co-payment Day Clinic = 10% co-payment of procedure	Subject to Overall Annual Limit	Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26 and PMB regulations
6.7	**Pre-Advanced Illness support:** For defined clinically appropriate conditions and risk categories	80% of the lower of cost or recommended tariff	Subject to Overall Annual Limit Subject to Annexure E	Subject to the treatment meeting the Scheme's treatment guidelines and clinical criteria. Basket of care as set by the Scheme



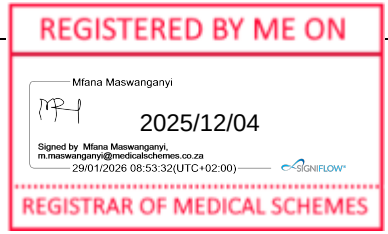
7	**DENTISTRY** Subject to the dentistry benefit management programme and the conditions and limits stipulated in paragraph 26			
7.1	**Basic dentistry**			
7.1.1	**Dental practitioners** Basic Dentistry includes consultation, restorations, extractions, root canal treatment and plastic dentures. Dental technician fees for all dentists, oral hygienists and dental therapists. It is funded at 80% of the claimed amount or the Scheme Rate, whichever is lower. Alternatively, for members that pay their contributions through debit order, the 20% portion will be debited from your account. If your provider charges more than the Scheme Rate, you will be required to pay the difference from your own pocket	80 % of the lower of the cost or recommended tariff	M0 R4 503 M1 R7 431 M2 R8 741 M3+ R10 028 Upfront payment for Basic dentistry performed In Hospital / Day Clinic: 12 years and younger – R3068 In Hospital / R1 389 in Day Clinic 13 years and older - R7 872 in Hospital / R5036 in Day Clinic	
7.1.2	**Dental therapists** For basic dentistry performed by dental therapists	80% of the lower of cost or recommended tariff		

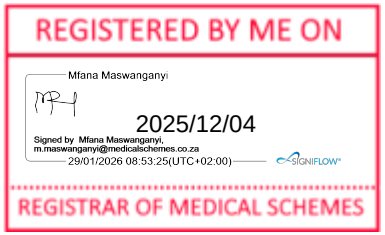
7.1.3	**Oral hygienist** For basic dentistry performed by an oral hygienist.	80% of the lower of cost or recommended tariff. Subject to day to day limit.		
7.2	**Advanced dentistry (No Benefit)** For inlays, crowns, bridges, mounted study models, metal base dentures, the treatment by periodontists (excluding oral medical procedures) and prosthodontists and the cost of dental technicians' fees for all such dentistry	No benefit	No benefit	
7.3	**Osseo-integrated implants & Orthognathic Surgery** (No Benefit) For all services rendered including the cost of special investigations, hospitalisation, 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	No benefit	No benefit	

7.4	**Oral surgery** For consultations, visits, and surgical procedures by maxillo-facial specialists and dental practitioners	100 % of the lower of cost or recommended tariff	Subject to Overall Annual Limit	Subject to the hospital management programme benefit
7.5	**Maxillo-facial surgery**	**100% of the lower of cost or recommended tariff**	Subject to Overall Annual Limit	Subject to the hospital benefit management programme See paragraph 24 (Surgical Procedures)
7.6	**Orthodontic treatment** **No Benefit**	No benefit	No benefit	
8	**HOSPITALISATION**			
8.1	**Private and public hospitals, registered unattached operating theatres, day clinics, sub-acute facilities and hospice - in hospital** This paragraph expressly excludes the benefit for hospitalisation arising out of osseo-integrated implants and orthognathic surgery (see paragraph 7.3), mental illness (see paragraph 12.1), refractive surgery (see paragraph 14.5) and pregnancy (see paragraph 19.1); PMB benefits are subject to Annexure E			
8.1.1	For accommodation in a general ward, high care ward and intensive care unit	100% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	
8.1.2	For theatre fees	100% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26
8.1.3	For materials and hospital equipment and the transport of blood	100% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	



8.1.4	Medicines	100% of the lower of cost or the price determined by the hospital benefit management programme plus the negotiated professional charge for medicines	Subject to Overall Annual Limit	
8.1.5	Medicines for a patient to take home (TTOs)	See paragraph 11.1.1.	See paragraph 11.1.1.	Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26
8.2	**Private and public hospitals – out of hospital** Subject to the conditions and limits stipulated in paragraph 26:			
8.2.1	For out-patient services and materials	100% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	
8.2.2	For medicines given to a patient to take home; see paragraph 11.1.1.	100% of the price as determined by the hospital benefit management programme plus the negotiated professional charge for medicines	See paragraph 11.1.1	
8.3	**Alternatives to hospitalisation: Step-down facility and private nursing** For all services rendered by private nursing and/or step down facilities	100% of the lower of the cost or recommended tariff	Subject to Overall	Subject to the hospital benefit management programme, the disease management programme and the conditions and limits stipulated in paragraph 26



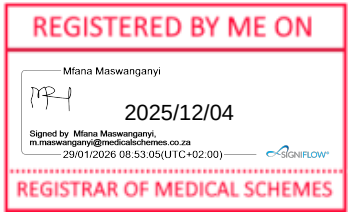
8.4	**Alternatives to hospitalisation: Rehabilitation centres** For accommodation, services, consumables and equipment at an approved facility	100% of the lower of the cost or recommended tariff	Annual Limit	Subject to the hospital benefit management programme, the disease management programme and the conditions and limits stipulated in paragraph 26
8.5	**Compassionate Care Benefit for non-oncology patients (inpatient care and home nursing)**	100% of the negotiated fee where applicable or 100% of the lower of cost between the negotiated fees and recommended tariff	R57 020 per person per lifetime and Subject to Overall Annual Limit	PMB benefits subject to Annexure E
8.6	**Hospital at Home (HAH) benefit**	100% of the negotiated fee where applicable or 100% of the lower of cost between the negotiated fees and recommended tariff	Subject to Overall Annual Limit	Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26
9	**IMMUNE DEFICIENCY RELATED TO HIV** Subject to the disease management programme, the routine medication programme, the extended or chronic medication programme and the conditions and limits stipulated in paragraph 26			
9.1	**Anti-retroviral medicines**	100% of the cost, plus a fixed dispensing fee per line item where applicable	Subject to Annexure E	
9.2	**Related medicines**	100% of the cost of medicines as determined by the routine medication programme or the extended or chronic medication programme plus the negotiated professional charge	Subject to Annexure E	

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9.3	**All other services related to HIV**	Subject to Annexure E	Subject to Annexure E	Benefits for all other services shall be subject to Annexure E. If the relevant beneficiary does not comply with the stipulated protocols of the Disease Management programme, the right to benefits will be subject to the Provisions of Regulation 8 to the Regulations (Code 902m) Medical Schemes Act
10	**INFERTILITY**	Subject to Annexure E	Subject to Annexure E	Subject to the hospital benefit management programme, benefits payable will be in respect of the medical and surgical management as outlined in Annexure A, of the PMB
11	**MEDICINES, DEVICES AND INJECTION MATERIAL** This paragraph expressly excludes medicines and devices in respect of alternative health care practitioners, (see paragraph 2), organ transplants (see paragraph 15) and oncology (see paragraph 16)			
11.1	**Acute sickness conditions** Subject to the routine medication programme and the conditions and limits stipulated in paragraph 26.			
11.1.1	**Legally prescribed acute medicine, including TTOs In respect of registered medicines including injection material, prescribed by a person legally entitled to prescribe**	80% of the lower of cost or the price as determined by the routine medication programme plus the negotiated dispensing fee charged	M0 R4 348 M1 R7134 M2 R8 073 M3+ R8 860 Further accumulates to the Overall Annual Limit	This paragraph excludes prescriptions supplied for use in a hospital but includes, without the payment of a levy, all medicines given to a patient to take home. Refer to Annexure C 3.10 for additional covered items.
11.1.2	**Contraceptives**	80% of the lower of cost or the price as determined by the routine medication programme plus the negotiated dispensing fee charged	Limited to R2 933 per female beneficiary for contraceptives	Subject to and included in acute medicine limits (paragraph 11.1.1). No accumulation to the Overall Annual Limit.

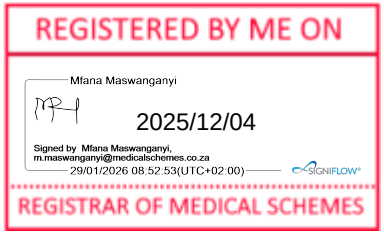
11.1.3	**Contraceptive Devices and Implants**	80% of the lower of cost or the price as determined by the routine medication programme plus the negotiated dispensing fee charged	Per frequency of the device	Per frequency of the device
11.1.4	**Pharmacy advised therapy (PAT)**	No benefit	No benefit	
11.2	**Chronic sickness conditions: Medicines other than anti-retroviral medicines** In respect of registered medicines and administrative devices prescribed by a person legally entitled to prescribe, where a member or dependant suffers from an extended or chronic sickness condition	100% of the cost determined by the extended or chronic medication programme plus the negotiated dispensing fee if obtained from a SABMAS Pharmacy Network; for non-use of the DSP, a 20% co-payment will apply	For 26 PMB CDL conditions only, subject to Annexure E Medicine Reference Pricing / MMAP applies	Subject to the extended or chronic medication programme and the conditions and limits stipulated in paragraph 26 Chronic list is detailed in paragraph 26
11.2.1	Continuous Blood glucose monitoring devices	Any beneficiary approved and registered on the Scheme's Chronic Illness Benefit for Diabetes is covered up to 100% of the Scheme Rate.	Limited to R44 015 every 5 years	The device must be approved by the Scheme, subject to the Scheme's protocols and clinical entry criteria.

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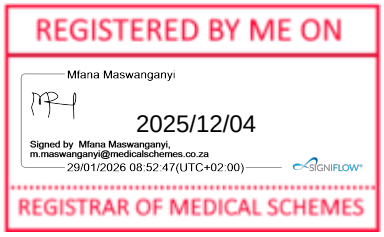
11.3	**Immunisation and vaccines** For providing and administering vaccines or immunisation for polio, rubella, measles, tetanus, diphtheria, mumps, flu, meningitis, hepatitis, whooping cough and pneumonia as prescribed by a person legally entitled to do so	80% of the lower of the cost or the price as determined by the routine medication programme, plus the negotiated professional charge	Subject to and included in acute medicine limits (paragraph 11.1.1)	See paragraph 11.1. Subject to acute medicine limit only where not covered as part of the SABMAS Wellness benefit (paragraph 25)
12	**MENTAL HEALTH BENEFIT**			
12.1	**Hospitalisation - Private and public hospitals** Subject to the hospital benefit management programme (applicable in hospital), the disease management programme and the conditions and limits stipulated in paragraph 26 and PMB regulations			
12.1.1	For accommodation in a general ward	100% of the lower of cost or negotiated tariff at network facility. 80% of the lower of cost or negotiated tariff at a non-network facility.	 R33 576 per beneficiary, including in-hospital consultations and procedures	At an approved facility PMB benefits subject to Annexure E
12.1.2	For electro convulsive therapy (ECT) fees	100% of the lower of cost or recommended tariff		
12.1.3	For materials and hospital equipment	100% of the lower of cost or recommended tariff		
12.1.4	Registered medicines	100% of the cost as determined by the hospital benefits management programme plus the negotiated professional charge		

12.2	**Consultations, visits and procedures** The Scheme designates the SABMAS Specialist Network as the Designated Service Provider for Specialist treatment in and out of hospital. These Service Providers shall for the purpose of this Annexure be referred to as Designated Service Providers (DSP's). The DSP will be responsible for the provision of all benefits including PMBs.			
12.2.1	**In hospital**			
	For consultations and visits at an approved facility	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff	Subject to and included in the limit of R35 523 for Mental Health - hospitalisation	PMB benefits subject to Annexure E
	For procedures of general practitioners, psychiatrists, psychologists and social workers	100% of the lower of cost or recommended tariff		
12.2.2	**Out of hospital**			
	For consultations and visits at an approved facility	80% of the negotiated fee where applicable or 80% of the lower of cost or recommended tariff Need to align with 100% consultation rate for GPs, psychologist and social workers, and 80% consultation for psychiatrist. The Specialist referral rules will apply.	R5 625 per family for out of hospital consultations and procedures Subject to Overall Annual Limit PMB Benefits subject to Annexure E	Subject to the treatment meeting the Scheme's treatment guidelines and managed care criteria. Basket of care as set by the Scheme

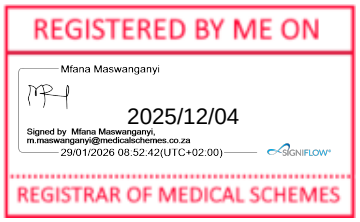
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12.2.2.1	For procedures of general practitioners, psychiatrists, psychologists and social workers at the supplier's rooms or in any facility or at any place other than a registered hospital	80% of the lower of cost or recommended tariff		
12.2.2.2	Disease management for major depression for members registered on the Scheme's Disease Management Programme	80% of the lower of cost or recommended tariff		
13	**NON-SURGICAL PROCEDURES AND TESTS** This paragraph expressly excludes psychiatry (see paragraph 12.2) and eye examinations (see paragraph 14.4)			
13.1	**In hospital** For all non-surgical procedures performed by a general practitioner or medical specialist	100% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	Subject to the hospital benefit management programme (applicable in hospital), the disease management programme and the conditions and limits stipulated in paragraph 26
13.2	**Out of hospital including practitioners' rooms** For all non-surgical procedures performed by a general practitioner or medical specialist	100% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	
14	**OPTICAL BENEFITS** Subject to the optical benefit management programme and the conditions and limits stipulated in paragraph 26			
14.1	**Readers**	100% of cost	up to R165 per beneficiary every 2 benefit years	Readers must be obtained from a registered optometrist
14.2	**Frames and Lens enhancements**	100% of cost	R1 431 per beneficiary every 2 benefit years	Frames limited to one pair of frames per beneficiary every 2 benefit years

14.3	**Spectacle lenses prescribed or supplied by a registered optometrist, ophthalmologist or supplementary optical practitioner**	100% of cost	Single vision lenses - R253 per lens Bifocal lenses - R 595 per lens Multifocal lenses -R 1 100 per lens	Spectacle lenses limited to one pair of lenses per beneficiary every 2 benefit years
14.4	**Contact lenses disposable and/or contact lenses (clinically essential)**	No benefit	No benefit	
14.5	**Eye examinations**	100% of the lower of cost or recommended tariff for eye examinations via a Preffered Provider Network Optometrist; or 80% of the lower of cost or recommended tariff if a non-network provider is used	R451 per beneficiary per benefit year 1 Consultation per beneficiary per benefit year	Benefit not exceeding the composite fee for multiple procedures for eye examinations and tests performed by optometrists or ophthalmologists when clinically essential
14.6	**Refractive surgery**	No benefit	No benefit	No benefit



15	**ORGAN TRANSPLANTS** Subject to the approval by the Scheme prior to the work-up for surgery, the hospital benefit management programme, the disease management programme and the conditions and limits stipulated in paragraph 26 and the PMB regulations			
15.1	For consultations, visits, the harvesting of the organ and transplantation thereof at an approved facility	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff	R80 578 per family	PMB benefits subject to Annexure E
15.2	For post-operative anti-rejection medicines	100% of the cost determined by the chronic medication programme plus the negotiated professional charge		
16	**ONCOLOGY** Subject to the hospital benefit management programme, the disease management programme and the conditions, benefit threshold limits and limits stipulated in paragraph 26 and the PMB regulations. A Benefit Threshold Limit equivalent to 80% of the Scheme rate becomes applicable after the Threshold Claim Amount has been reached. The Threshold Claim amount is R250 000 per beneficiary for a period of 12 months from the date of registration on the benefit.			
16.1	For consultations, visits and for treatment and materials used in radiotherapy and chemotherapy	100% of the negotiated fee where applicable or 100% of the lower of cost between the negotiated fees and recommended tariff	Subject to Benefit Threshold Limit and Overall Annual Limit	PMB benefits subject to Annexure E
16.2	In respect of registered medicines used in radiotherapy and chemotherapy	100% of the cost determined by the hospital benefit management programme plus the	Subject to Benefit Threshold Limit and Overall Annual Limit	PMB benefits subject to Annexure E

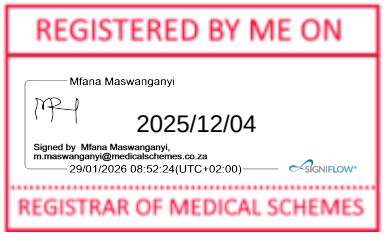


		negotiated professional charge		
16.3	Advanced Illness Benefit for oncology patients	100% of the negotiated fee where applicable or 100% of the lower of cost between the negotiated fees and recommended tariff	Subject to the Overall Annual Limit	PMB benefits subject to Annexure E
17	**PATHOLOGY AND MEDICAL TECHNOLOGY** Subject to the hospital benefit management programme (applicable in hospital), the disease management programme and the conditions and limits stipulated in paragraph 26			
17.1	**In hospital** For all tests performed by a pathologist or medical technologist	100% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	
17.2	**Out of hospital** For all tests performed by a pathologist or medical technologist	80% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	
18	**BACK AND NECK PROGRAM (PHYSIOTHERAPY, BIOKINETICS AND CHIROPRACTORS)** This will come from the Risk Benefit, subject to registration on back and neck programme and DSP usage and managed care protocols. This will be annual Benefit.			
18.1	**Out of hospital (Registered on the program)** For physiotherapy, biokinetics and chiropractors	100% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	Annual Benefit
18.2	**Out of hospital (Not registered)** For physiotherapy and biokinetics (No benefit for chiropractors)	80% of the lower of cost or recommended tariff	R2 310 per family per annum from day to day benefit	Annual Benefit

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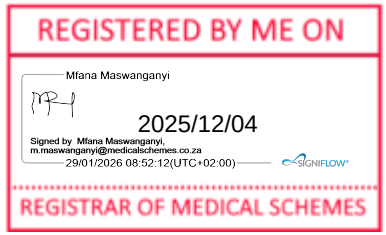
18.3	**In hospital** For physiotherapy, biokinetics and chiropractors	100% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	
19	**PREGNANCY AND CHILDBIRTH** Subject to the hospital benefit management programme and the conditions and limits stipulated in paragraph 26			
19.1	**Hospitalisation (Public or private hospitals)**			
19.1.1	• For accommodation, theatre fees, labour ward fees, drugs, dressings and materials in a private or provincial hospital • For drugs, dressings, medicines and materials supplied by a midwife	100% of the lower of cost or recommended tariff	Normal Deliveries – subject to the maternity programme and Overall Annual Limit Caesarean Sections – subject to the maternity programme and limited to R30 026 per confinement	Limit can be exceeded if clinically appropriate for non-elective caesarean sections, subject to the Overall Annual Limit.
19.1.2	In respect of registered medicines prescribed by a person legally entitled to prescribe or supplied by a midwife	100% of the cost as determined by the routine medication programme or the extended or chronic medication programme plus the negotiated professional charge		
19.2	**Medical services and midwifery**			
19.2.1	For ante-natal consultations.	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff	12 per pregnancy Subject to Overall Annual Limit	

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19.2.2	For pregnancy scans and other pregnancy related tests	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff	Scans and related tests – 2X 2D-scans per pregnancy Subject to Overall Annual Limit	
19.2.3	For the delivery by a general practitioner, medical specialist or midwife			
19.2.4	For post-natal care by a midwife and other practitioners			
20	**PROSTHESIS – INTERNAL AND EXTERNAL** Subject to the hospital benefit management programme and limits stipulated in paragraph 26			
20.1	**Internal**	100% of the cost	R78 458 per family No benefit for elective knee and hip replacement surgery. For PMB approved hip and knee prostheses, the Internal and External Prostheses limit will apply if a non-preferred supplier is used	Limit accumulation subject to DSP usage in section C
20.2	**External**	100% of the cost		
21	**RENAL DIALYSIS (ACUTE AND CHRONIC)** For consultations, visits and all services and materials associated with the cost of renal dialysis at an approved facility	100% of the negotiated fee where applicable or 100% of the lower of cost or recommended tariff	R72 190 per family	Subject to the hospital benefit management programme, the prior approval of the Scheme and the conditions and limits stipulated in paragraph 26 and the PMB regulations PMB benefits subject to Annexure E

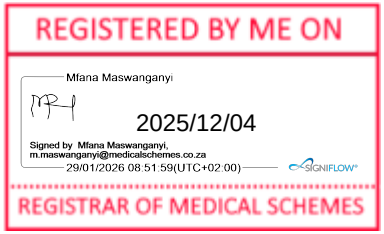
22	**RADIOLOGY AND RADIOGRAPHY** Subject to the conditions and limits stipulated in paragraph 26			
22.1	**General radiology**			
22.1.1	**In hospital** For diagnostic radiology tests, scans, and mammograms	100% of the lower of the cost or recommended tariff	Subject to Overall Annual Limit	
22.1.2	**Out of hospital** For diagnostic radiology tests, scans, and mammograms	80% of the lower of the cost or recommended tariff	Subject to Overall Annual Limit	
22.2	**Specialised radiology**			
22.2.1	**In-hospital** Magnetic Resonance Images, CT scans, PET scans and nuclear medicine (excluding nuclear medicines for treatment of oncology), bone densitometry, and angiograms	100% of the lower of cost or recommended tariff	Limit of R18 706 per family per year	Subject to the hospital benefit management programme
22.2.2	**Out of hospital** Magnetic Resonance Images, CT scans, and bone densitometry	100% of the lower of cost or recommended tariff		Subject to the hospital benefit management programme

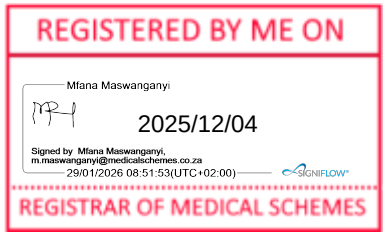
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23	**REMEDIAL AND OTHER THERAPIES** Subject to the conditions and limits stipulated in paragraph 26			
23.1	For services in respect of: • Audiology • Dietetics • Hearing aid acoustics • Occupational therapy • Orthoptics • Podiatry • Speech therapy	80% of the lower of cost or recommended tariff	R2 593 per family collectively for all services	
24	**SURGICAL PROCEDURES** For surgical procedures performed by a general practitioner, medical specialist and clinical technologist	100% of the lower of cost or recommended tariff	Subject to Overall Annual Limit	This paragraph expressly excludes services provided in respect of osseointegrated implants and orthognathic surgery (see paragraph 7.3), refractive surgery (see paragraph 14.5) and organ transplants (see paragraph 15) and pregnancy (see paragraph 19) Subject to the hospital benefit management programme, the disease management programme and the conditions and limits stipulated in paragraph 26

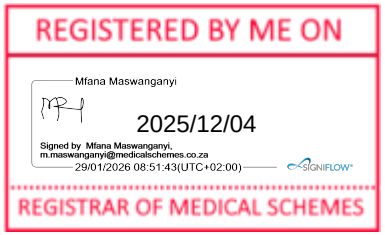
25	**SABMAS WELLNESS** Wellness benefits are provided as additional insured benefits, which do not contribute to the depletion of any other insured limits (or savings) specified elsewhere in these rules. Once available Wellness benefits have been used, normal category limits apply. Note: Except in the case of PMBs, any consultations and costs not specifically stated in this section but related to the specified tests will be paid from relevant category limits			
25.1	**Immunisation Programmes**			
25.1.1	Child immunisation programme: as per the Department of Health's recommended immunisation program	100% of the lower of cost or recommended tariff	As per the Department of Health's guidelines	
25.1.2	Tetanus ~~diphtheria~~ booster: as required	100% of the lower of cost or recommended tariff	As required	
25.1.3	Influenza vaccination: All beneficiaries: one every year	100% of the lower of cost or recommended tariff	One every year	
25.1.4	Pneumococcal vaccination: beneficiaries aged 60 years and older, and high-risk individuals:	100% of the lower of cost or recommended tariff	One every year	
25.1.5	HPV vaccination: All beneficiaries aged 9 - 24 years (2 doses)	100% of the lower of cost or recommended tariff	2 doses per lifetime	
25.2	**Early Detection Programmes**			
25.2.1	Full general physical examination	100% of the lower of cost or recommended tariff	Subject to the GP and nurse practitioners Consultation Limit	

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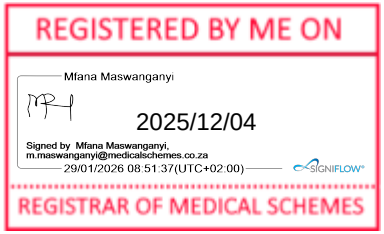
25.2.2	Mammogram: females aged 40 years and older: For high-risk females aged 40 years and younger on motivation	100% of the lower of cost or recommended tariff. Allow sonar procedure reimbursement (subject to prior authorisation) – where patients are under the age of 40 and present with an abnormal mammogram result and require a sonar procedure to assist with further diagnosis.	Every 2 years	To be funded from the wellness benefit
25.2.3	Prostate specific antigen test Male 40-49 years: one every 5 years Male 50-59 years: one every 3 years Male 60-69 years: one every 2 years Male aged over 70 years: one every year	100% of the lower of cost or recommended tariff	As indicated	
25.2.4	DEXA scan male and female older than 50 years: one every 3 years	100% of the lower of cost or recommended tariff	One every 3 years	

25.2.5	Health assessment tests: one every year • BMI (Body Mass Index): All adult beneficiaries • Blood sugar test (finger prick): All adult beneficiaries • Blood pressure test: All adult beneficiaries • Cholesterol test (Finger Prick): All adult beneficiaries	100% of the lower of cost or recommended tariff	One every year, as indicated	
25.2.6	Cholesterol blood test	100% of the lower of cost or recommended tariff	As indicated	
25.2.7	Blood sugar blood test	100% of the lower of cost or recommended tariff	As indicated	
25.2.8	HIV test: male and female: one every year HIV finger prick test: male and female: one every year	100% of the lower of cost or recommended tariff	One every year Additional tests will be paid from day-to-day benefits	To be funded from the wellness benefit.
25.2.9	Pap smear: female: Cytology one every 3 years HPV test one every 5 years	100% of the lower of cost or recommended	Consultation subject to Overall Annual Limit	To be funded from the wellness benefit PMB benefits subject to Annexure E

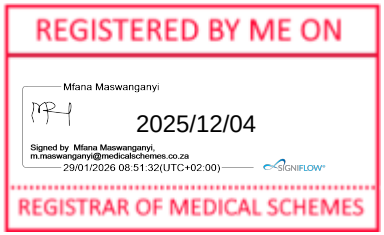
25.2.10	Glaucoma Test • Beneficiaries 40-49 years: once every 2 years • Beneficiaries 50+: once a year	100% of the lower of cost or recommended tariff	One every year	
25.2.11	**Dentistry:** General full mouth examination by a general dentist or oral hygienist (including sterile tray and gloves), plus polishing and scaling ~~one per beneficiary per year~~	100% of the lower of cost or recommended tariff	One per beneficiary per year	REGISTERED BY ME ON Mfana Maswanganyi 2025/12/04 Signed by Mfana Maswanganyi, m.maswanganyi@medicalschemes.co.za 29/01/2026 08:51:48(UTC+02:00) SIGNIFLOW REGISTRAR OF MEDICAL SCHEMES
25.2.11	**Dentistry:** General full mouth examination by a general dentist or oral hygienist (including sterile tray and gloves), plus polishing and scaling ~~one per beneficiary per year~~	100% of the lower of cost or recommended tariff	One per beneficiary per year	

25.2.12	Maternity Blood Tests: 1 test per female beneficiary per pregnancy, subject to registration on the maternity programme: • Antiglobulin Test (Coombs) • HIV Ab/Elisa (At least 2 per pregnancy) • Full Blood Count • Grouping: Rh antigen • Rubella-IgM: Specific antibody titer: ELISA/EMIT: Per Ag • Quantitative Khan VDLR or other Flocculation (TPHA) • Beta HCG Qualitative &/Or Quantitative • Hepatitis B H306 Surface antigen	100% of the lower of cost or recommended	 As indicated, per pregnancy	Subject to registration on the maternity programme:
25.2.13	Colon Cancer Faecal Occult blood test	100% of the lower of cost or recommended tariff	One every 2 years	

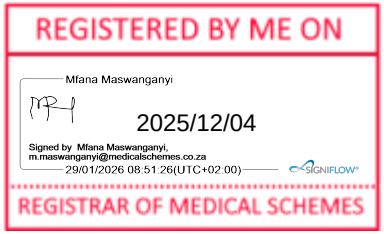
	World Health Organization (WHO) Global Outbreak Benefit			
	Basket of care which includes inhospital and out-of-hospital management and supportive treatment of global World Health Organization recognized disease outbreaks such as: - COVID-19 - Monkeypox	100% of the lower of cost or recommended tariff for services within the basket of care.	In hospital: Unlimited Out of hospital: Subject to Day-to-Day limit	PMB benefits subject to Annexure E Treatment will be funded at 100% of cost at a designated service provider. Subject to the Scheme's Designated Service Provider (DSP) protocols and clinical entry criteria.
26	**BENEFIT LIMITS**			
26.1	The benefits provided in terms of paragraphs 1 to 24 have annual limits as stipulated in the table above.			
26.2	**OVERALL ANNUAL LIMIT (OAL)** R545 290 per family All benefits on the Essential Option are subject collectively to an annual overall limit of R545 290 per family; subject to an inner category limit, where indicated.			
26.3	Where no limitation of the benefit is indicated as a category limit, the benefit is only limited to the overall annual limit.			
26.4	**Dependant categories**			
	Dependant categories are stated thus:			
	Member without dependants: M0			
	Member with one dependant: M1			
	Member with two dependants: M2			
	Member with three or more dependants: M3+			



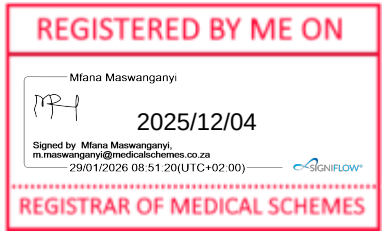
26.5	**Day Clinic Procedures** List
	Ear, Nose & Throat Surgery (ENT)
	• Tonsillectomy
	• Laryngoscopy
	• Eustachian tube dilatation
	• Intranasal antrostomies
	• Bronchoscopy
	• Myringotomy with grommet insertion
	Ophthalmology
	• Cataracts GI / local block
	• Pterygium
	• Evisceration of eye
	• Vitrectomy
	• Phacoemulsification
	• Posterior vitrectomy and PPV
	Gynaecology
	• Cauterization of vaginal warts
	• Dilatation & curetation
	• LLETZ biopsy colposcopy
	• Hysteroscopy
	• Cyst excision



	Urology
	• Circumcision
	• Prostate biopsy
	• Vasectomy
	• Brachytherapy
	• Cystoscopy and bladder biopsy
	• Ureteroscopy
	General Surgery
	• Skin lesion repairs
	• Excision of melanoma
	• Ingrown toenail removal
	• Sebaceous cyst excision
	• Haemorrhoidectomy
	• Incision and drainage of abscess
	• Proctoscopy
	Orthopaedic Surgery
	• Arthroscopy shoulder, knee, elbow, wrist & ankle
	• Dupuytren's
	• Prosthesis/external fixators removal
	• Trigger finger release



	Dental procedures
	• Extractions
	• Fillings
	• Polishing
	• Pulpotomies
	• Root canals
	Maxillo facial procedures
	• All Impacted teeth
	Neurosurgery
	• Facet blocks
	• Infiltrations
	• Rhizotomies
	• Proctoscopy
	Orthopaedic Surgery
	• Arthroscopy shoulder, knee, elbow, wrist & ankle
	• Dupuytren's
	• Exploration of tendon and repair
	• Ganglion/carpal tunnel
	• Hardware insertion & removal
	• Trigger finger release



	Dental procedures
	• Extractions
	• Fillings
	• Polishing
	• Pulpotomies
	• Root canals
	Maxillo facial procedures
	• Impacted teeth
	• Implants
	• Ridge augmentations
	• Wisdom teeth
	Neurosurgery
	• Facet blocks
	• Infiltrations
	• Rhizotomies

