

DE BEERS BENEFIT SOCIETY
ANNEXURE B
BENEFITS WITH EFFECT FROM 1 JANUARY 2026

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Subject to the rules of the SOCIETY, MEMBERS and their DEPENDANTS are entitled to the benefits specified in this Annexure B.

1. DEFINITIONS

1.1. “Agreed cost”

the cost negotiated by the SOCIETY with a supplier for the provision of medical equipment or supplies.

1.2. “Formulary”

the evidence-based list of medication, published by the SOCIETY, for which benefits will be provided to treat specified conditions.

1.3. “Formulary Reference Price Plus (FRP Plus)”

the maximum rate at which the SOCIETY will provide benefits for medication that does not form part of the SOCIETY’s FORMULARY.

1.4. “Mediscor Reference Price (MRP)”

the average price, as determine by the SOCIETY, of any group of legislated single exit prices of any generic equivalent of any originator or clone medicine obtained by a Beneficiary.

1.5. “Negotiated Rate”

in respect of services obtained from a hospital, the rates the Society has negotiated with its preferred provider network hospitals as the rates at which these network hospitals will charge members and at which rate the Society will reimburse these DESIGNATED SERVICE PROVIDER (network) hospitals in respect of services obtained directly from such hospitals.

1.6. “Prescribed treatment”

the treatment prescribed by regulation for a PRESCRIBED MINIMUM BENEFIT CONDITION.

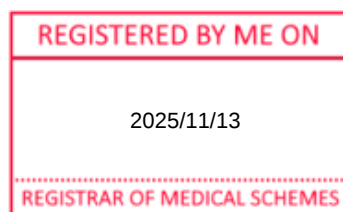
1.7. “Society Recommended Price List (SRPL)”

the rate at which the SOCIETY will pay for relevant health services, which rate is calculated on the schedule of tariffs formerly known as the National Health Reference Price List subject to annual increases approved by the Board.

1.8. “Scheme rate”

1.8.1. in respect of professional health care services obtained in a preferred provider hospital, a rate not exceeding 165% of the SOCIETY RECOMMENDED PRICE LIST for the relevant service; or

1.8.2. in respect of Society pre-authorised in-room procedures and preauthorised admissions to day clinic or sub-acute facilities, a rate not exceeding 165% of the Society Recommended Price List for the relevant service.



1.9. “SEP”

means the VAT inclusive single exit price of the Medicine determined by the Department of Health's dispensing fee regulations.

2. PRESCRIBED MINIMUM BENEFITS (PMB)

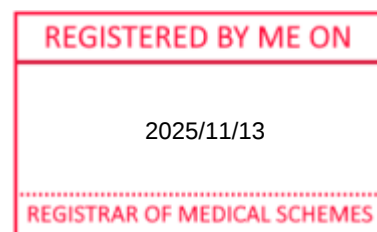
All the below benefits, definitions and guidelines are subject to PRESCRIBED MINIMUM BENEFITS as set out and defined in the “Medical Schemes Act, No. 131 of 1998”.

2.1. Designated Service Providers (DSP)

The SOCIETY designates the following service providers (in this Annexure B referred to as DESIGNATED SERVICE PROVIDERS OR DSP) for the delivery of PRESCRIBED MINIMUM BENEFITS to its BENEFICIARIES:

2.1.1. CHRONIC AND PMB MEDICINE DESIGNATED SERVICE PROVIDERS

- Dis-Chem Pharmacies (PTY) LTD
- Dis-Chem Direct
- Cullinan Health and Home Pharmacy
- Namaqualand Pharmacy (Springbok)
- Dr HA Burger (Namaqualand)



2.1.2. EMERGENCY TRANSPORT DESIGNATED SERVICE PROVIDER

- ER24

2.1.3. HOSPITAL DESIGNATED SERVICE PROVIDER

- Preferred Provider Network Hospitals
- Specialist facilities including, but not limited to, psychiatric facilities

2.1.4. ONCOLOGY DESIGNATED SERVICE PROVIDER

- Independent Clinical Oncology Network - (ICON)

2.1.5. OPTICAL SERVICES DESIGNATED SERVICE PROVIDER

- Preferred Provider Negotiators - (PPN)

2.1.6. RENAL DIALYSIS DESIGNATED SERVICE PROVIDER

- BBraun Avitum / E Owen & Partners Incorporated

2.2. Prescribed minimum benefits obtained from Designated Service Providers

Subject to the further provisions set out below, the SOCIETY shall pay 100% of the cost of PRESCRIBED TREATMENT provided in respect of PRESCRIBED MINIMUM BENEFIT CONDITIONS provided that these services are obtained from a DESIGNATED SERVICE PROVIDER.



2.3. Prescribed minimum benefits voluntarily obtained from non-designated service providers

If a BENEFICIARY voluntarily obtains diagnosis, treatment and care in respect of a PRESCRIBED MINIMUM BENEFIT CONDITION from a provider other than a DESIGNATED SERVICE PROVIDER, the benefit payable in respect of such service is subject to such benefit limitations as are normally applicable in terms of the rules of the SOCIETY and shall not exceed the benefit that would have been available and/or payable had the DESIGNATED SERVICE PROVIDER been used.

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2.4. Prescribed minimum benefits involuntarily obtained from non-designated service providers

2.4.1. If a BENEFICIARY involuntarily obtains diagnosis, treatment and care in respect of a PRESCRIBED MINIMUM BENEFIT CONDITION from a provider other than a DESIGNATED SERVICE PROVIDER, the SOCIETY shall pay 100% of the cost of PRESCRIBED TREATMENT provided in relation to such PRESCRIBED MINIMUM BENEFIT CONDITION.

2.4.2. For the purposes of paragraph 2.4.1, a BENEFICIARY will be deemed to have involuntarily obtained a service from a provider other than a DESIGNATED SERVICE PROVIDER, if:

2.4.2.1. the service was not available or could not be obtained without unreasonable delay from a DESIGNATED SERVICE PROVIDER;

2.4.2.2. immediate medical or surgical treatment for a PRESCRIBED MINIMUM BENEFIT CONDITION was required under circumstances or at locations which reasonably precluded the BENEFICIARY from obtaining such treatment from a DESIGNATED SERVICE PROVIDER; or

2.4.2.3. there was no DESIGNATED SERVICE PROVIDER within reasonable proximity to the BENEFICIARY'S ordinary place of business or personal residence.

2.5. Medication

2.5.1. Where a PRESCRIBED MINIMUM BENEFIT includes medication, the SOCIETY will pay 100% of the cost of that medication if that medication is obtained from a DESIGNATED SERVICE PROVIDER and complies with the SOCIETY'S medicine FORMULARY as determined by the BOARD from time to time, or is involuntarily obtained from a provider other than a DESIGNATED SERVICE PROVIDER, and

2.5.1.1. the medication is included on the FORMULARY in use by the SOCIETY; or

2.5.1.2. the medication is a drug that is clinically appropriate and effective for the treatment of that PRESCRIBED MINIMUM BENEFIT CONDITION, and is normally available to any public hospital patient.

2.5.2. Where a PRESCRIBED MINIMUM BENEFIT includes medication, benefit limitations normally applicable in terms of the rules of the Society will apply if:

2.5.2.1. that medication is voluntarily obtained from a provider other than a DESIGNATED SERVICE PROVIDER, or

- 2.5.2.2.** the FORMULARY includes a drug that is clinically appropriate and effective for the treatment of a PRESCRIBED MINIMUM BENEFIT condition suffered by a BENEFICIARY, and that BENEFICIARY declines the formulary drug and opts to use another drug instead.

2.6. Prescribed minimum benefits obtained from a public hospital

Notwithstanding anything to the contrary contained in these rules, the SOCIETY shall pay 100% of the costs of PRESCRIBED MINIMUM BENEFITS obtained from a public hospital, provided the services obtained are no different from the services available to any other public hospital patient.

2.7. Diagnostic tests for an unconfirmed prescribed minimum benefit condition

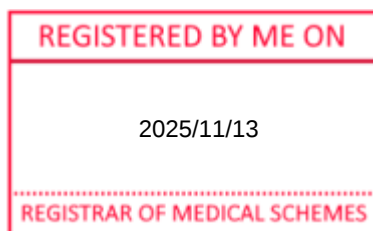
Where diagnostic tests and examinations are performed, other than in respect of an EMERGENCY MEDICAL CONDITION, but do not result in confirmation of a PRESCRIBED MINIMUM BENEFIT CONDITION, such diagnostic tests or examinations are not considered to be a PRESCRIBED MINIMUM BENEFIT.

2.8. Managed Care

Unless specifically prohibited by the ACT, the foregoing provisions shall not prevent the SOCIETY from employing appropriate interventions aimed at improving the efficiency and effectiveness of health care provision, including requirements for pre-authorisation, the application of treatment protocols and the use of formularies. All such interventions contained in the benefit schedule shall equally apply to the PRESCRIBED MINIMUM BENEFITS. The SOCIETY may authorise cost effective evidence-based treatment algorithms for PRESCRIBED MINIMUM BENEFITS in terms of regulation 15H and 15I of the ACT where appropriate.

3. MEDICATION IN RESPECT OF CHRONIC CONDITIONS OTHER THAN THE PRESCRIBED CHRONIC CONDITIONS

- 3.1.** In addition to the benefits available in respect of the chronic conditions included in the PRESCRIBED MINIMUM BENEFITS, BENEFICIARIES may, subject to the conditions set out in the Benefit Schedule and other provisions of the rules, be entitled to a chronic medication benefit in respect of the chronic conditions listed below (non-prescribed conditions covered):



1. Acne	16. Meniere's Disease
2. Allergic Rhinitis	17. Menopausal and
3. Attention Deficit Hyperactivity Disorder	Perimenopausal Disorders
4. Alzheimers Disease	18. Motor Neuron Disease
5. Ankylosing Spondylitis	19. Myasthenia Gravis
6. Benign Prostatic Hypertrophy	20. Osteoarthritis
7. Cushing Disease	21. Osteoporosis
8. Cystic Fibrosis	22. Paget's Disease
9. Deep Vein Thrombosis	23. Paraplegia, Quadriplegia
10. Gastro-oesophageal Reflux Disorder	24. Peripheral Vascular Disease
11. Gout	25. Pituitary Adenomas
12. Hypoparathyroidism	26. Psoriasis
13. Hyperthyroidism	27. Pulmonary Interstitial Fibrosis
14. Incontinence	28. Stroke / Cerebrovascular Accident
15. Depression	29. Systemic Connective Tissue Disorders (incl. Scleroderma and Dermatomyositis)

In the case of the treatment of medical conditions reflected in the above table which may attract prescribed minimum benefit entitlement in terms of the diagnosis and treatment pairs as per Annexure A to the Regulations of the ACT, they will be reimbursed as PRESCRIBED MINIMUM BENEFITS as per Regulation 8.

- 3.2.** Approval of any medicines for the treatment of any of the above conditions for purposes of the chronic medication benefit shall be solely at the discretion of the SOCIETY unless the medicine concerned is normally available to a public hospital patient for the treatment of a PRESCRIBED MINIMUM BENEFIT CONDITION.

4. PRE-AUTHORISATION

- 4.1.** All hospital benefits, including PRESCRIBED MINIMUM BENEFITS in respect of hospitalisation and other treatment as set out in the benefit schedule, are subject to pre-authorisation for the impending admission of a BENEFICIARY to a hospital or day clinic, or for the commencement of such other treatment provided in-rooms, sought from and granted by the SOCIETY, not less than five full working days prior to such admission or the commencement of such other treatment.

- 4.2.** In cases of an EMERGENCY MEDICAL CONDITION during periods when the offices of the SOCIETY are closed and it is not possible to obtain pre-authorisation from the SOCIETY prior to admission to a hospital prior to such treatment commencing, the SOCIETY must be notified of such admission or such other treatment on the first BUSINESS DAY following the date of such admission to a hospital.

- 4.3.** If no pre-authorisation as detailed in 4.1 and 4.2 above is obtained from the Society OR a claim is received without valid authorisation:

- 4.3.1.** a 30% co-payment will be applied to the total cost of the hospital benefits that would normally be subject to pre-authorisation for a hospital or day clinic admission; and

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- 4.3.2.** In all other cases where pre-authorisation by the Society is required (except for admissions as detailed in 4.3.1 above) a fixed R500 co-payment may be applied to the benefit that would normally be subject to pre-authorisation.
- 4.4.** Neither the process of seeking pre-authorisation from the SOCIETY prior to or following an admission to a hospital or day clinic, or for treatment provided in-rooms, nor the issue of a pre-authorisation number or letter by the SOCIETY in respect of such admission shall constitute a guarantee of payment in respect of any claims arising from such admission.
- 4.5.** The issuing of a pre-authorisation number or letter serves only to confirm that the proposed clinical procedure or treatment plan complies with clinical and funding protocols and does not guarantee that benefits will be paid.
- 4.6.** All chronic medication benefits, including PRESCRIBED MINIMUM CHRONIC MEDICATION BENEFITS, are subject to pre-authorisation and registration on the SOCIETY'S chronic medication program.
- 4.7.** A claim for the payment of chronic medication benefits in the absence of pre-authorisation shall be treated as a claim for acute medication and may be rejected for authorisation from the second fill.
- 4.8.** All pre-authorisations will be dealt with in terms of the SOCIETY'S or its appointed managed care organisation's protocols and/or formularies.

5. MISCELLANEOUS PROVISIONS

- 5.1.** All benefits will be calculated according to the SOCIETY'S RECOMMENDED PRICE LIST; however if these services are obtained from a Designated Service Provider hospital, approved day-clinic, approved sub-acute facility or are in respect of any procedure/s performed in a doctor's rooms, such benefits shall be calculated at the SCHEME RATE.
- 5.2.** In cases where the SOCIETY deems the cost/benefit of a new drug (acute or chronic medication) to be uncertain, a co-payment may be applied calculated as the difference between the cost of the new product and the reference price of a suitable alternative intended to treat the same condition as determined by the SOCIETY from time-to-time.
- 5.3.** Where the maximum benefit value in respect of a particular health service as provided for in these rules has been exceeded, the MEMBER concerned shall be liable to pay the relevant supplier directly (or from available credit limit where applicable) for the costs of such health services that exceed the maximum benefit value.
- 5.4.** Where the SOCIETY has entered into a preferred provider arrangement with a provider, or a group of providers, the SOCIETY shall not be liable for the costs of services obtained by BENEFICIARIES from any other providers without the prior written authorisation of the SOCIETY, provided that if such authorisation is granted by the SOCIETY, such benefit shall not exceed the benefit that would have been payable had a preferred provider been utilised. In respect of a PRESCRIBED MINIMUM BENEFIT, the PRESCRIBED MINIMUM BENEFIT rules shall apply.

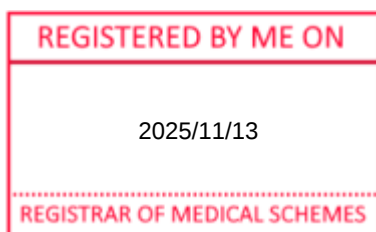
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- 5.5.** Unless otherwise provided for, maximum benefits shall be calculated from 1 January to 31 December of each year (annual limit), based on the services rendered during that year.
- 5.6.** Benefits are not transferable from one financial year to another, from one benefit category to another or from one BENEFICIARY to another, except if it is specifically indicated in the benefit schedule.
- 5.7.** Subject to rule 15.5, claims not submitted to the SOCIETY before the end of the fourth month after the month in which the service was rendered shall not be paid for by the SOCIETY.
- 5.8.** All benefits listed, unless otherwise stated, are per beneficiary.



6. BENEFIT SCHEDULE

	SERVICE	% BENEFIT	LIMITS	CONDITIONS/REMARKS
A	STATUTORY PRESCRIBED MINIMUM BENEFITS (PMB) REGISTERED BY ME ON 2025/11/13 REGISTRAR OF MEDICAL SCHEMES	100% of diagnosis, treatment and care costs of the prescribed treatment		Benefits are subject to the provisions set out in paragraph 2 in this annexure and shall, insofar as may be applicable, override any restrictions or limitations imposed in respect of benefits set out below. Notwithstanding any provisions to the contrary in this schedule, the Society will fund: - 100% of diagnosis, treatment and care costs of the PMB's subject to PMB regulations, if those services are obtained from a DSP; or - the relevant SRPL for the diagnosis, treatment and care costs of the PMB's if a beneficiary voluntarily accesses PMB's via a non-DSP, subject to PMB regulations; or - 100% of cost for involuntary use of a non-DSP, subject to PMB regulations. When limits are specified in this schedule, the limit will first be utilised for the payment of the relevant claims, and thereafter continued funding will apply for PMB claims only, subject to PMB regulations. Diagnosis costs are only regarded as PMB if the result of the diagnostic investigations confirms a PMB diagnosis.

	SERVICE	% BENEFIT	LIMITS	CONDITIONS/REMARKS
B	HOSPITAL			
	Hospital stays (Including Day Cases, Fixed Fee Cases for Cataracts, In-rooms procedures in lieu of hospitalisation and alternative facilities) REGISTERED BY ME ON 2025/11/13 REGISTRAR OF MEDICAL SCHEMES	100% of SRPL or Scheme Rate	Unlimited	Subject to pre-authorisation and managed care protocols in a facility and manner which the Society deems appropriate. The SRPL rate applies to all non-DSP hospital authorisations for service providers and hospital costs and for a facility not deemed appropriate. Negotiated Rate applies to DSP network hospital authorisations, day clinics, fixed fee cataract procedures and sub-acute facilities hospital costs. Scheme Rate applies to service providers for authorisations within the DSP network hospitals. A co-payment of R1 500 per procedure authorised will apply to all colonoscopies, gastroscopies, circumcisions, vasectomies and intravitreal injections authorised to take place in-hospital. The Society in its discretion may waive any co-payment in respect of treatment and procedures associated with an approved hospital admission. Where two or more of the above procedures are performed simultaneously in-hospital, only one co-payment will be levied. Scheme Rate applies to procedures pre-authorised out of hospital.



	SERVICE	% BENEFIT	LIMITS	CONDITIONS/REMARKS
	REGISTERED BY ME ON 2025/11/13 REGISTRAR OF MEDICAL SCHEMES			A co-payment of R1 500 will apply to all arthroscopic and laparoscopic procedures performed for diagnostic purposes. The following laparoscopic procedures may be authorised in terms of the Society's protocols but will be subject to a capped overall benefit limit (inclusive of all hospital costs); Laparoscopic assisted vaginal hysterectomy (R50 440), Laparoscopic unilateral inguinal hernia (R39 330), Laparoscopic incisional/ventral hernia (R62 550). RALP (Robotic assisted laparoscopic prostatectomy) capped overall at R184 990 – being made up of the capped fee for the hospital procedure only, at R117 730, and this includes the anaesthetic time limited to a maximum of 3 hours. All the associated providers are capped at a combined total of R67 260 for the RALP.
	Professional Fees in hospital	100% of SRPL or Scheme Rate		Subject to managed care protocols and limits where applicable.
	Hospital medicines	100% of SEP	Unlimited	Subject to managed care protocols Maximum of seven days' supply in respect of take-out medicines on discharge.



	SERVICE	% BENEFIT	LIMITS	CONDITIONS/REMARKS
	Internal prosthesis REGISTERED BY ME ON 2025/11/13 REGISTRAR OF MEDICAL SCHEMES	100% of SRPL or Scheme Rate	Overall internal prosthesis limit: R65 040.	Subject to pre-authorisation and managed care protocols. Limits include all associated costs e.g. bone cement, cages, screws and plates. PMB regulations to apply when the limit has been reached. Sub-limits (The sub-limits below accumulate to the overall internal prosthesis limit): Joint replacements R65 040; Spinal prosthesis R65 040; Mesh (Gortex, TVT slings and Permacol ®) R18 550; coronary and vascular stents, pacemakers, aortic and mitral valve replacements R65 040.
	Cochlear implants	100% of SRPL or Scheme Rate	Device limit of R338 190 per lifetime	Subject to pre-authorisation and managed care protocols. Limit applies to device (internal and external components) only. Replacement or repair of the external processing system will be paid from the Hearing Aid benefit.
	Psychiatric hospitalisation for treatment of mental disorders	100% of SRPL or Negotiated Rate	An overall limit of 21 days provided that the treatment of PMB conditions are limited as per Annexure A of the Regulations.	Subject to pre-authorisation and managed care protocols. Negotiated Rate will only be provided for preferred provider hospitals and registered mental health hospital (55 Practice).



	SERVICE	% BENEFIT	LIMITS	CONDITIONS/REMARKS
	Alcohol and drug dependency hospital rehabilitation	100% of SRPL or Negotiated Rate	An overall limit of 24 days provided that the treatment of PMB conditions are limited as per Annexure A of the Regulations.	REGISTERED BY ME ON 2025/11/13 REGISTRAR OF MEDICAL SCHEMES
	Blood transfusion	100% of SRPL or Scheme Rate or Agreed Cost	Unlimited	
	Maxillofacial and oral surgery	100% of SRPL or Scheme Rate		Subject to pre-authorisation and managed care protocols. No benefit is provided for osseo-integrated implants and orthognathic surgery.
	Physiotherapy	100% of SRPL or Scheme Rate		Subject to pre-authorisation and managed care protocols.
	Occupational and speech therapy and dietician	100% of SRPL or Scheme Rate		Subject to pre-authorisation and managed care protocols.
	Maternity	100% of SRPL or Scheme Rate	Limited to 2 days hospitalisation for normal delivery and	Subject to pre-authorisation and managed care protocols.



	SERVICE	% BENEFIT	LIMITS	CONDITIONS/REMARKS
			3 days hospitalisation for a caesarean delivery.	
C	CONSULTATIONS			
	Nursing practitioner	100% of SRPL	R2 250	Consultations and procedures in rooms. The following in-room procedures must be pre-authorized and will be reimbursed at Scheme Rate: gastroscopy, colonoscopy, vasectomy, circumcision and intravitreal injection. For elective non-emergency after hour consultations, the benefit shall be limited to the SRPL for a normal consultation (Code: 0190).
	General Practitioner and Specialist procedures in-rooms	Scheme Rate	Unlimited	
	General Practitioner, Homeopath and Specialist consultations Virtual Consultations	90% of SRPL 100% of SRPL	Combined limit of 12 visits 2 visits	
D	DENTISTRY (IN AND OUT OF HOSPITAL)			
	Conservative dentistry (Includes preventative and diagnostic consultations, cleanings, fillings, extractions and X-rays)	100% of SRPL	R5 310 with a sub-limit of 1 check-up and scale and polish every 6 months	For elective procedures where general anaesthesia is required for conservative dentistry on children under the age of 9 (limited to one admission per annum); the removal of impacted wisdom teeth; apicectomies; removal of teeth and roots or exposure of teeth for orthodontic reasons; pre-authorization is required and is subject to managed care protocols.

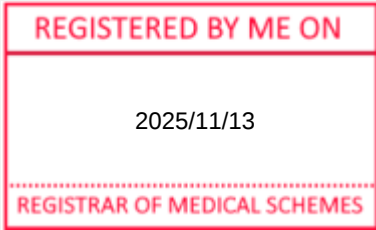
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	SERVICE	% BENEFIT	LIMITS	CONDITIONS/REMARKS
				No limit applies in respect of dentistry required as a result of trauma.
	Specialised dentistry (Includes crowns, dentures, bridges and periodontal treatment)	100% of SRPL	R10 150	Subject to pre-authorisation and managed care protocols for procedures performed in hospital.
	Orthodontic treatment	75% of SRPL	R29 220 per lifetime	Subject to pre-authorisation and managed care protocols. No benefit in respect of treatment commencing after 18 th birthday.
E	MEDICINES			
	Acute medication (Includes prescribed Homeopathic medication and contraceptive preparations and devices)	85% of the negotiated DSP rate	- Member = R4 557 - Member + 1 Dependant = R6 608 - Member + 2 Dependant = R9 251 - Maximum = R12 489	The Mediscor Reference Price (MRP) will apply where a generic medicine exists and the additional cost of any medication obtained voluntarily at a value above this reference price will be the beneficiary's liability. REGISTERED BY ME ON 2025/11/13 REGISTRAR OF MEDICAL SCHEMES



	SERVICE	% BENEFIT	LIMITS	CONDITIONS/REMARKS
	Over the counter (OTC) medication. Vaccinations	100% of the negotiated DSP rate 100% of the negotiated DSP rate	Subject to the acute medication limit Unlimited	Maximum R145 per event with a sub-limit of a maximum of 6 fills per year. All vaccinations not excluded by the Society, age restriction and managed care protocols may apply.
	Chronic medication 	100% of the negotiated DSP rate	R46 010 for both the chronic conditions listed in 3.1 above and the PMB chronic conditions, where after benefits will only apply for prescribed treatment in respect of chronic PMB conditions once the limit has been reached.	Chronic medication for the non-prescribed and prescribed conditions are subject to pre-authorisation and registration on the Chronic Medication Program and subject to the approved formulary. Chronic medication benefit in respect of non-prescribed and prescribed chronic conditions only applies to chronic medicine dispensed by a designated service provider. Benefits for chronic medicine in respect of non-prescribed and prescribed chronic conditions voluntarily obtained from a non-designated service provider will be limited to 70% of the amount that would have been payable had the medicine been obtained from the designated service provider. The Mediscor Reference Price (MRP) will apply where a generic or clone medicine exists and the additional cost of any medication obtained voluntarily at a value above this reference price will be the beneficiary's liability. The Society Formulary (FRP Plus) is applicable to all



	SERVICE	% BENEFIT	LIMITS	CONDITIONS/REMARKS
	REGISTERED BY ME ON 2025/11/13 REGISTRAR OF MEDICAL SCHEMES All Biologicals (sub-limit for Chronic medicine and Oncology)		R271 380	chronic disease list prescribed medication (Listed in 3.1 above as well as the PMB list). A co-payment equivalent to the difference between the cost of the formulary drug and that of the negotiated DSP rate for the prescribed drug will apply. Medicines used for the treatment of ADHD will only be funded from the chronic medicine benefit until the end of the year in which the beneficiary turns 18. Motivation by a psychiatrist will be considered by Mediscor, subject to their protocol, for chronic medicine benefit authorisation requests after the 18th birthday. Subject to pre-authorisation, managed care protocols and available limit for chronic medicine.
F	DIAGNOSTIC TESTING			
	Pathology	100% of SRPL or Scheme Rate In hospital 90% of SRPL Out	Unlimited	Subject to request by a medical practitioner.



	SERVICE	% BENEFIT	LIMITS	CONDITIONS/REMARKS
		of hospital		
	Radiology	100% of SRPL or Scheme Rate In hospital 90% of SRPL Out of hospital	Unlimited	Subject to request by a medical practitioner. 1 Bone density scan every 2 years for all beneficiaries over the age of 50 paid at 100% of SRPL.
	MRI/CAT Scans	100% of SRPL	Limited to 3 scans per family	Subject to pre-authorisation and managed care protocols.
	PET and related CT planning scans	100% of SRPL	Will accrue to oncology limit	Subject to pre-authorisation and managed care protocols.
G	AMBULANCE SERVICES			
	REGISTERED BY ME ON 2025/11/13 REGISTRAR OF MEDICAL SCHEMES	100% of cost for emergency transport to hospital and for inter-hospital transfers, if pre- authorised by the designated service	Unlimited if pre- authorised and provided by the designated service provider.	ER24 is the designated service provider for all emergency and ambulance services. No benefit when declined by the DSP or where the DSP is not utilised.



	SERVICE	% BENEFIT	LIMITS	CONDITIONS/REMARKS
		provider		
H	MEDICAL EQUIPMENT			
	Aids and Appliances Such as insulin pumps, continuous glucose monitoring (CGM) devices including all test strips, orthopaedic boots, surgical collars, prosthesis, nebulisers, and hiring of equipment	50% of agreed cost	R9 630	Subject to pre-authorisation, managed care protocols and motivated by a doctor's prescription. The benefit limit will increase annually for each category despite the fixed five-year period. The type of appliance covered by this benefit will be at the discretion of the Society and all repairs and maintenance are included in the limit to a sub-limit maximum of 15% of the limit per category. REGISTERED BY ME ON 2025/11/13 REGISTRAR OF MEDICAL SCHEMES No benefit payable in respect of hearing aid batteries.
	Colostomy Bags and Catheters	100% of agreed cost	R24 250	
	Continuous Oxygen Supply Machine and or Oxygen	100% of agreed cost	R25 020	
	Artificial Limbs (including prosthetic eyes)	90% of agreed cost	R65 100 every fixed 5 years (starting from 1 Jan 2026)	
	Hearing Aids	90% of agreed cost	25 470 every fixed 5 years (starting from 1 Jan 2026)	
	Wheelchair	90% of agreed cost	R12 150 (or R36 870 for quadriplegics and paraplegics only),	



	SERVICE	% BENEFIT	LIMITS	CONDITIONS/REMARKS
	REGISTERED BY ME ON 2025/11/13 REGISTRAR OF MEDICAL SCHEMES		every fixed 5 years (starting from 1 Jan 2026)	No benefit for motorised carts/tricycles, other than motorised wheelchairs in appropriate cases and all repairs and maintenance are included in the limit to a sub-limit maximum of 20% of the limit.
I	EYE CARE			
	1. Composite consultation (Including Refraction, glaucoma screening, visual field screening and artificial intelligence screening for retinopathy) 2. Frame and Lens Enhancements 3. Lenses (per lens) a. Single vision or b. Bifocal or c. Multifocal	100% of the Preferred Provider Negotiators (PPN) agreed tariffs	R955-50 for a PPN network provider or R400 R420 for a non-network provider R1 940 for a PPN network provider or R1 552 for a non-network provider. R225 R485 R900	The benefit limit extends over a two-year cycle. The two-year cycle commences on 1 January 2026 for all beneficiaries. The benefit values quoted are only applicable to the current benefit year in which a valid claim is paid within each two-year cycle. Frame and lens enhancement benefit can be used for the frame or lens enhancements or a combination of both. No liability for repairs of damage to, or loss of spectacles. Prescriptions less than 0.50 dioptré will not be covered. No bi/multifocal lenses with a reading of less than 1.00 dioptré will be covered; Bi/multifocal for under 40-year-old beneficiaries must be motivated. Contact lenses for children under 16 years of age must be motivated. Beneficiaries can claim either spectacles or contact lenses



[illegible]

	SERVICE	% BENEFIT	LIMITS	CONDITIONS/REMARKS
	Refractive Surgery Including but not limited to Excimer Laser and eye surgery required for Astigmatism, Hypermetropia, Presbyopia, Myopia and Hypermyopia	50% of SRPL or Scheme Rate In and Out of hospital and associated providers	Refractive surgery is limited to one procedure per eye per lifetime.	Subject to pre-authorisation and managed care protocols. Lenses limited to single vision lenses.
	Intra-ocular lenses	100% of SRPL or Scheme Rate	Limited to single vision lenses and to a maximum of R4 090 per lens.	Subject to pre-authorisation and managed care protocols.
J	CARE NOT IN HOSPITAL			
	Audiology, Chiropractic, Podiatry, Acupuncture, Dietician services, Occupational and Speech Therapy.	90% of SRPL	Overall limit of R4 390	REGISTERED BY ME ON 2025/11/13 REGISTRAR OF MEDICAL SCHEMES



	SERVICE	% BENEFIT	LIMITS	CONDITIONS/REMARKS
	Physiotherapy including Biokinetics and Chiropractic Services	90% of SRPL	R8 510	
	Private Nursing	90% of SRPL	R13 410 subject to PMB's	Pre-authorisation is required and the provider must be a registered provider.
	Wound care	90% of SRPL	R13 410 subject to PMB's	Subject to pre-authorisation and managed care protocols.
	Hospice Care	Subject to PMB's	Subject to PMB's	Pre-authorisation of a treatment plan is required
	Home confinement / Natural birth delivery	100% of SRPL	Limited to the in- hospital maternity benefit costs	Subject to pre-authorisation and managed care protocols.
K	MENTAL HEALTH OUT OF HOSPITAL			
	Not in hospital	90% of SRPL	R17 660	
L	ONCOLOGY			
	Treatment Out of Hospital	Negotiated Rate	R368 980 including all PET and CT planning and	Subject to pre-authorisation and managed care protocols of the ICON Advanced Option including 6 follow-up visits at an ICON provider.

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	SERVICE	% BENEFIT	LIMITS	CONDITIONS/REMARKS
	Treatment In Hospital	Negotiated Rate for services provided by ICON provider and 100% of SRPL or Scheme Rate for associated provider costs	related planning scans.	Benefits for oncology consultations and all treatment voluntarily sought from non-designated service providers will be limited to 80% of the amount that would have been payable at the SRPL. Oncology consultations are logged to the oncology overall benefit. REGISTERED BY ME ON 2025/11/13 REGISTRAR OF MEDICAL SCHEMES
	All Biologicals (sub-limit for Chronic medicine and Oncology)		R271 380	Genetic testing relating to oncology requires separate pre-authorisation and will be considered if clinically appropriate and if it has the potential to influence the treatment of the diagnosed cancer. All chronic prescription parenteral medicine for oncology treatment must be obtained from Dis-Chem Direct Subject to pre-authorisation, managed care protocols and available limit for oncology treatment.



	SERVICE	% BENEFIT	LIMITS	CONDITIONS/REMARKS
M	CHRONIC RENAL DIALYSIS			
	Applicable only to PMB confirmed cases	100% of Negotiated Rate In and Out of hospital	Unlimited	Subject to pre-authorisation and managed care protocols.
N	ORGAN TRANSPLANTS			
	Applicable only to PMB confirmed cases	100% of SRPL or Scheme Rate In hospital	Unlimited	Subject to pre-authorisation and managed care protocols.
P	CORNEAL TRANSPLANTS			
		100% of SRPL or Scheme Rate In hospital	R14 740 graft limit plus harvesting costs limited to R19 180	Subject to pre-authorisation and managed care protocols.

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