ENGEN MEDICAL BENEFIT FUND

ANNEXURE B

Schedule of Benefits 2025

PREAMBLE

1. Subject to limitations and exclusions set out in Annexure C, the Statutory Prescribed Minimum Benefits and the provisions of the Rules of the Fund, members and their dependants are entitled to the benefits set out in this Annexure B in respect of treatment received from the first day of membership. Prolonged treatment may be subject to review.
2. Members admitted during a financial year shall be entitled to the benefits set out herein with the maximum benefits being adjusted in proportion to the period of membership during that financial year, calculated from the admission date to the end of that financial year.
3. No member shall be entitled to assign, transfer, pledge, hypothecate or cede his benefits, or rights to benefits, in or from the Fund.
4. All claims must be submitted in accordance with Rule 15.
5. Benefits are not transferable from one benefit period to another or from one category to another.
6. The Fund shall enter, or cause to be entered, such arrangements or contracts with private hospitals or hospital groups, including, but not limited to, Alternative Reimbursement agreements, as may be considered appropriate. Benefit entitlements shall be at the agreed rate according to the arrangement, agreement, or contract if services are provided by these providers.

	SERVICE	BENEFIT (Subject to annual limits)	ANNUAL LIMITS	CONDITIONS / REMARKS
1	**STATUTORY PRESCRIBED MINIMUM BENEFITS AS PER ANNEXURE D**			
		1. Services to be provided by Designated Service Providers (DSP) 2. For purposes of the Prescribed Minimum Benefits, DSPs are: 2.1 ER24 for Ambulance Services 2.2 GPs in the Discovery Health GP Network; 2.3 GPs in the KeyCare GP Network; 2.4 The Premier Plus GP Network for the management of HIV/AIDS, Diabetes and Cardio Care and Mental Health; 2.5 The Discovery Health Premier A and Premier B Specialist Networks 2.6 Specialists in the KeyCare Specialist Network 2.7 The KeyCare Hospital Network; 2.8 DSP pharmacies in the Oncology Pharmacy Network for the supply of oncology medicine 2.9 The Day Surgery Network of providers for a defined list of procedures, as indicated in Annexure F of these Rules. 2.10 All other providers with whom the Scheme has contracted for specific services, as indicated in this Annexure B and Annexure D of these Rules.		
1.1	Benefits contemplated in Section 29(1)(o) of the Act as per Annexure D	100% of the cost, subject to the use of relevant DSPs	No limit	1. Subject pre-authorisation clinical criteria and hospital case management. 2. Elective, in-hospital treatment, and care paid at cost subject to the use of a PMB DSP Hospital 3. If non-DSP services are used voluntarily, claims paid up to the Fund Rate only
1.2	General and Specialist Practitioner services (consultations in hospital)	Up to 100% of the cost subject to the use of the DSP or for involuntary use of non-DSP	Unlimited	1. Excludes radiology and pathology (refer to 1.4 below) 2.Subject to preauthorisation, clinical criteria, and hospital case management 3. Up to 100% of the Fund Rate for voluntary use of non-DSP
1.3	General and Specialist Practitioner services (consultations out of hospital) (in doctor's rooms and virtual and tele consultations)	Up to 100% of the cost at DSP or for involuntary use of non-DSP	Subject to baskets of care for each of the CDL conditions	1. Subject to authorisation of benefits as contemplated in 1.5 below and DTPMB 2. Applicable basket of care benefits is automatically available once benefits are authorised under 1.5 below 3. Benefits subject to clinical criteria 4. Up to 100% of the Fund Rate if non-DSP services are used voluntarily.
1.4	Radiology and Pathology Subject to PMB	100% of the cost from DSP or for	Subject to baskets of care for each of the CDL conditions	1. Subject to authorisation of benefits as contemplated in 1.5 below and DTPMB

		involuntary use of non-DSP		2. Applicable basket of care benefits is automatically available once benefits are authorised under 1.5 below 3. Benefits subject to clinical criteria 4. Up to 100% of the Fund Rate for voluntary use of the services of a non-DSP
1.5	Chronic Medication	100% of the cost	Limited to PMB CDL conditions	1. Subject to chronic application and authorisation according to the Fund's PMB formulary 2. Paid up to a Chronic Drug Amount (which is the lowest cost formulary drug) for voluntary use of non-formulary medicine 3. If a co-payment is applied to the medicine dispensed by a pharmacy, the member will be personally liable for settling the amount directly with the pharmacy
2	**HOSPITALISATION AND RELATED BENEFITS**			
	Preamble 1. Preauthorisation must be obtained at least 48 hours before admission to hospital for non-emergency hospitalisation, surgical procedures, and before CT or MRI scans are performed. In the case of an emergency, or after hours' admission, the Fund shall be notified within 24 hours, or on the first working day following the admission, of such an emergency or treatment having been initiated, failing which the provision of paragraph 2.3 of this preamble will apply. Notwithstanding anything to the contrary, the Fund shall not refuse such authorisation or preauthorisation for a Prescribed Benefit. 2. In respect of benefits set out in this Annexure B, the following principles will apply in all cases where preauthorisation is required: 2.1 If preauthorisation is obtained, but the treatment exceeds what was authorised, benefits will accrue for the authorised treatment only; 2.2 The cost in excess of the authorisation, will be payable by the member. Application may be made retrospectively for review in respect of treatment in excess of what was initially authorised. 2.3 If treatment is undergone without preauthorisation having been obtained, application may be made retrospectively for an authorisation. Should such authorisation be granted (except in an emergency) the benefit will be subject to a non-notification penalty of R1 000. If authorisation is declined, no benefits will accrue, subject to Prescribed Minimum Benefits, as provided for in Rule 16. 3. Benefits paid under this section of the Rules shall not be charged to the Medical Savings Account benefits			
2.1	Accommodation: *General ward, high care, intensive care, or labour ward; use of the recovery room, theatre fees and anaesthetics administered in the theatre*	100% of the Fund Rate	Unlimited	1. Subject to preauthorisation 2. No benefit shall be paid for non-registered unattached theatres

2.2	Medicines, materials, and hospital equipment *Includes costs of ward and theatre drugs, dressings, materials consumed, and equipment used in hospital*	100% of the Fund Rate	Unlimited	Subject to preauthorisation
2.3	To Take Out (TTO) medicines (on discharge)	100% of the cost	7 days' supply per beneficiary per admission	Subject to preauthorisation of the admission
2.4	In hospital operations, surgical procedures, and consultations *Includes in hospital GP, Specialists and ante-natal consultations, the cost of anaesthesia, endoscopic procedures related to the actual procedure, and the costs for assistants at surgical procedures, operations, or confinements*	100% of the Fund Rate	Unlimited	1. Subject to preauthorisation 
2.5	Day Surgery Procedures *Applicable to a defined list of procedures as per Annexure F of these Rules*	100% of the Fund Rate	Unlimited	1. Subject to authorisation, clinical criteria and the services being obtained at a facility in the Fund's DSP 2. If the service of non-DSP is used voluntarily**,** a deductible of R7 000 applies per admission
2.6	Step-down, recuperation, and rehabilitation facilities *For services in lieu of hospitalisation*	100% of the Fund Rate	Unlimited	1. Subject to preauthorisation, 2. The facility must be registered with the Department of Health 3. Private nursing / frail care / hospice paid from the Primary Care (day to day) Benefit
2.7	Pre-operative Assessment *for the following major surgeries: Arthroplasty, colorectal surgery, coronary artery bypass graft, radical prostatectomy, and mastectomy*	100% of the Fund Rate	Paid once per procedure	Subject to a benefit basket, authorisation and/or approval and the treatment meeting the Fund's clinical entry criteria, treatment guidelines and protocols
2.8	Post-operative or rehabilitation care *Post-operative physio-, occupational- or speech therapy;* *Surgical appliances*	100% of the Fund Rate 100% of the cost	Limited to a period of 6 weeks	Benefit availability limited to a period of 6-weeks from date of discharge, for the same condition for which the patient was hospitalised initially
2.9	Maxillo-facial or oral surgery	100% of the Fund Rate	Unlimited	Subject to preauthorisation and PMB

2.10	Basic dental trauma procedures *for a sudden and unanticipated impact injury because of an accident or injury to teeth and the mouth, resulting in partial or complete loss of one or more teeth that requires urgent care in- or out-of-hospital*	100% of the Fund Rate	Limited to R64 390 per beneficiary per year	Subject to pre-authorisation, clinical entry criteria, treatment guidelines and protocols An upfront payment (deductible) applies if performed in-hospital or at a day clinic: Hospital: < than 13 years – R3 140 > 13 years – R8 170 Day clinics: < than 13 years – R1 410 > 13 years – R5 240 The deductible is payable by the member to the facility. Includes cover for dentist and other related accounts, irrespective of the place of service, and cover for dental appliances and prostheses, and the placement thereof, as well as orthodontics (surgical and non-surgical). All costs related to the procedure accumulate to the limit.
2.11	Spinal Care Programme *In and out of hospital management of spinal care and surgery for defined clinically appropriate procedures, which include Lumbar Fusion, Cervical Fusion, Laminectomy, Laminotomy*	100% of the Fund Rate at Network Hospital	Unlimited	1. Spinal surgery subject to preauthorisation and basket of care in a Hospital in the Spinal Network 2. Subject to a 20% co-payment if the services of non-Network Hospitals are used 3. Basket of care as set by the Fund for out-of-hospital conservative treatment. Subject to authorisation, treatment guidelines and clinical criteria, limited to one procedure per year
	Spinal prostheses or devices	100% of the Fund Rate	Limited to R27 500 for one level; R55 000 for two or more levels.	4. Paid in full if obtained from Scheme's DSP. If device is not obtained from DSP, the indicated limits apply
2.12	Member Care Programme *for proactively managing beneficiaries who are identified to have complex care needs, including chronic condition management*	100% of The Fund Rate	Unlimited	1. Subject to identification and registration by the Fund; 2. Subject to clinical and managed care guidelines 3. Specific limits as per available benefits will apply
20.13	Home-based acute care, including devices for home-monitoring (based	100% of the Fund Rate	Unlimited	Subject to clinical criteria and pre-authorisation

	on clinical need) for qualifying members • in lieu of hospitalisation, • after early discharge, or • as a continuation of care after discharge from hospital, or • Home-based readmission prevention			Subject to the Fund's basket of care 
2.14	Internal prostheses	100% of the Fund Rate	Multiple external or internal prostheses subject to a joint limit of R105 960 per beneficiary per year	1. Subject to prior approval 2. Defined as appliances placed in the body as an internal adjuvant during an operation, or as the replacement of artificial eyes and limbs 3. Dental implants of any nature are not included in the definition of internal prostheses 4. Several Network structures apply: <u>Hip or Knee replacement devices</u> Unlimited at a network provider. Limited to R30 900 per prosthesis per admission if not supplied by a Network provider <u>Shoulder replacement devices</u> Unlimited if prosthesis is supplied by the Fund's network provider. Limited to R45 550 per prosthesis per admission if prosthesis is not supplied by the Fund's network provider <u>Cardiac stents (max 3 per beneficiary per year)</u> Unlimited if stent is supplied by the Fund's network provider. Limited per stent per if device is not supplied by a network provider: Drug-eluting stent: R14 950 Bare metal stent: R10 650 <u>Pacemakers</u> Unlimited if pacemaker is supplied by the Fund's Network provider. If not supplied by the Fund's Network supplier, paid up the Fund rate for the device

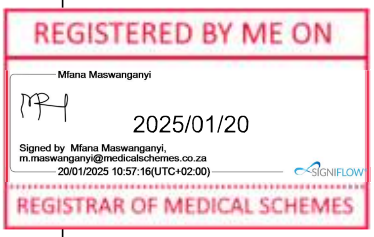
				Internal cardiac defibrillators Unlimited from a Network provider. If not supplied by the Network provider, paid up to the Fund rate for the device
	Artificial limbs Below the knee Above the knee		R28 160 R47 430	per beneficiary per year
	Artificial eyes		R28 160	per beneficiary per year
	Finger joint prostheses		R7 010	per beneficiary per year
	Aortic aneurism repair grafts		R187 620	per beneficiary per year
	Cardiac valves		R44 920	per valve
2.15	Advanced Illness Benefit *Out of hospital palliative care for members with life-limiting conditions, including cancer*	100% of the Fund Rate, unless PMB	Unlimited, subject to a basket of care	1. Subject to clinical criteria and preauthorisation 2. Psychosocial support, medical care from dedicated teams and Hospice, supportive treatment such as oxygen, pain control and home-based nursing
2.16	Advanced Illness Member Support Programme *For patients with advanced illnesses, requiring support at a time when they are trying to manage their symptoms, and understand their healthcare needs*	100% of the Fund Rate	Unlimited, subject to a basket of care	Subject to clinical criteria and registration on the Programme
2.17	Oncology *Including chemotherapy, medicines and materials used, radiation in- and out of hospital and PET Scans*	Subject to PMB Non-PMB claims paid up to 100% of the Fund Rate up to the threshold, thereafter at 80%	Unlimited A threshold of R250 000 applies per beneficiary per year for non-PMB claims	1. Subject to approval, clinical criteria, a treatment plan, the use of the services of the Fund's Preferred Providers /DSPs as may be applicable, and medicine supplied being on the Fund's list of preferred products. 2. All claims accumulate to the threshold
2.18	Chronic appliances *Includes oxygen products, cylinders and ventilation*	100% of cost	Limited to R31 410 per family per year, subject to PMB	1. Subject to authorisation. 2. Subject to the use of the Fund's DSP for oxygen products.

	expenses, and stoma products			3. If the services of the DSP are not used, claims paid up to the Fund Rate only
2.19	Organ transplants *Includes hospitalisation, organ and patient preparation, medication in- and out-of-hospital, harvesting and transportation of the organ*	Subject to PMB Non-PMB claims paid up to 100% of the Fund Rate	Limited to R528 740 per family per year for non-PMB procedures	1. Subject to preauthorisation 2. No benefits for travelling and accommodation
2.20	Renal dialysis *Includes procedure, treatment, associated medicines and drugs*	100% of the Fund Rate	Unlimited	1. Subject to ongoing case management, preauthorisation
2.21	Mental health *Subject to PMB only*	100% of the cost for PMB	Limited to 21 days in hospital or 15 psychotherapy sessions	1. Subject to preauthorisation, 2. In and out of hospital treatment subject to an overall limit of 21 days
2.22	Drug or Alcohol rehabilitation Subject to PMB only Detox treatment	100% of the cost for PMB	Limited to 21 days Limited to 3 days	1. Subject to preauthorisation 2. In hospital treatment only
2.23	Ambulance services *Includes emergency ambulance transport services to the nearest hospital, or inter-hospital transfers*	100% of the agreed rate	Unlimited	1. All non-emergency ambulance transport subject to authorisation by the DSP 2. If ambulance transport is not authorised, claims paid up to the Fund rate only, subject to PMB
2.24	MRI or CT scans (in- or out-of-hospital) *Subject to PMB*	100% of the Fund Rate	Limited to 2 scans per beneficiary per year	1. Additional scans subject to authorisation 2. A co-payment of R1 000 applies per scan 3.
2.25	Surgical procedures performed in doctors' rooms *In lieu of hospitalisation*	100% of the Fund Rate	Unlimited	1. Subject to authorisation 2. Minor procedures performed by GPs paid subject to 5.2
2.26	Radiology or Pathology *Includes radiology, x-rays, pathology (in-hospital) and endoscopic procedures done in a doctor's rooms*	100% of the Fund Rate	Unlimited	Subject to authorisation
2.27	Clinical and medical technologists *Includes services rendered, materials and apparatus supplied*	100% of the Fund Rate	Unlimited	No authorisation required

2.28	Blood transfusions	100% of the Fund Rate	Unlimited	No authorisation required
2.29	Medical and surgical appliances *Including hearing aids, wheelchairs and wigs*	100% of the cost	Limited to R30 000 per family per year	1. Excludes prostheses provided for in 2.18 above 2. Includes appliances not covered under the post-operative / rehabilitation or the chronic appliances benefit 3. Hearing aids, including supply and fitment / repair of the device paid at 100% of the net cost after discount: - the overall limit applies in a 2-year cycle - must be fully motivated by an audiologist's report. - . 4. Wheelchairs: the overall limit, applies in a 3-year cycle. 5. Wigs (non-cancer related / alopecia): limited to R5 000 per wig and 1 wig per person per year, subject to the overall limit.
2.30	HIV /AIDS and related illnesses Medicine	100% of the agreed rate at DSP 100% of MMAP	Unlimited	1. Subject to preauthorisation and the services being rendered by DSP providers 2. Subject to enrollment on the HIV*Care* Programme
2.31	World Health Organization (WHO) Outbreak Benefit *For out-of-hospital management and supportive treatment of global WHO recognised disease outbreaks* 1. COVID-19 treatment and care *Subject to PMB* 2. M-Pox	100% of the Fund Rate Subject to PMB	Subject to Fund's defined basket of care for the specific condition	Subject to the use of the services of the Fund's DSP / Preferred Providers, as may apply, protocols and the condition and treatment meeting the Fund's entry criteria and guidelines

3	**CHRONIC AND SPECIALISED MEDICINE**			
3.1	Non-PMB chronic medicine subject to the Additional Conditions List (ADL) as defined in Annexure G of these Rules *Includes approved medicine or injection material*	100% of the Fund Medicine Rate	Limited to R16 440 for a Single Member; R32 040 for a family	1. Excludes cover for PMB conditions and the medicine or injection material supplied, or administered in a hospital or nursing home 2. Paid up to the Fund Medicine Rate or ADL (where applicable) for the specific condition, subject to preauthorisation 3. If a co-payment is applied, the member must settle the amount due directly with the dispensing pharmacy
3.2	Specialty medicine benefit	100% of the Fund Rate	Limited to R186 780 per family per year	1. This benefit relates to a defined list of specialty medicine 2. Subject to clinical motivation and authorisation
3.3	Bluetooth enabled glucose monitoring devices	100% of the Fund Rate	Limited to one device per beneficiary per year	1. Subject to registration on the Fund's Chronic Illness Benefit for Diabetes
3.4	Continuous glucose monitoring sensors benefit	100% of the Fund Rate	Sensors limited to R1 675 per beneficiary per month Transmitter/reader: one device per beneficiary per year	1. Subject to registration on the Fund's Chronic Illness Benefit for Diabetes I, approval, clinical entry criteria and guidelines 2. A limit of R4 820 applies for the purchase of a transmitter or reader, subject to the limit in 2.29 above
4	**MATERNITY**			
	The benefits listed under this heading apply specifically in relation to pre- and post-natal care and children under the age of 2 years The benefits will not be paid for from the Primary Care Benefits			
4.1	Consultations	100% of the Fund Rate	12 visits per pregnancy 1 visit per pregnancy 2 sessions per pregnancy 1 visit per pregnancy	Midwife, GP or gynaecologist ante-natal consultations during pregnancy. Midwife, GP or gynaecologist consultation after the delivery. Consultations with a counsellor or psychologist for pre- or post-natal mental healthcare services. Lactation consultation with a registered nurse or lactation specialist

			2 visits per child < 2 years old	GP, paediatrician, or ENT visits for registered children under the age of 2 years
4.2	Ante-natal ultrasound examinations	100% of the Fund Rate	Limited to 2 examinations per pregnancy	All ultrasound scans, including 3D and 4D scans, paid at the rate for 2D scans only
4.3	Ante-natal classes (in- and out of hospital) *Includes exercise classes and/or visits*	100% of the Fund Rate	Limited to 5 per confinement	Ante-natal classes, or pre-and-post natal consultations, with a registered nurse
4.4	Nutrition assessment	100% of the Fund rate	Limited to 1 assessment	Nutrition assessment with a dietician after the delivery
4.5	Pathology	100% of the Fund Rate	Restricted to defined benefits only	For a defined basket of pregnancy blood tests
4.6	Genetic / chromosome screenings	100% of the Fund Rate	One of the listed tests per pregnancy	Nuchal Translucency Test, or Non-invasive Prenatal Test (NIPT), or T21 Chromosome Test
4.7	Pregnancy-related External Medical Items	75% of the Fund Rate	R5 970 per pregnancy	For registered essential devices such as breast pumps or nebulisers
5.	**Trauma Recovery Benefit (TREB)**			
	Over and above the DTPMB entitlement, this benefit covers out-of-hospital healthcare services arising from an emergency trauma-related event resulting in the following PMB conditions: Paraplegia, Quadriplegia, Near-drowning related injuries, Severe anaphylactic reactions, Poisoning, Crime-related injuries, Severe burns, External and internal head injuries or Loss of limbs. • Paid from Health Care Cover, subject to applicable limits. • Excludes OTC medicines (inclusive of schedule 0, 1 and 2 drugs whether prescribed or not), optometry, antenatal classes, and dentistry (other than severe dental and oral procedures contemplated under the Maxillo-facial and oral surgery benefit). • Cover applies to 31 December of the year following the year in which the trauma occurred. • Subject to authorisation and/or approval and treatment meeting the Fund's entry criteria.			
5.1	Allied, therapeutic and psychology healthcare professionals	100% of the Fund Rate	Limited to: M R23 350 M+1 R31 720 M+2 R38 690 M+3 R44 860	
5.2	Prescribed medicine (schedule 3 and up)	100% of the Fund Medicine Rate	M R6 490 M+1 R9 630 M+2 R10 990 M+3 R12 670 M+4+ R14 130 per year	1. Joint limit for all Prescribed Medicine, whether trauma-related or not. 2. These benefits are pro-rated when the member joins during a benefit year.
5.3	External Medical and surgical Items	100% of the Fund Rate	Limited to R30 000 per family per year	Subject to the Medical and Surgical Items Benefit.
5.4	Prosthetic limbs	100% of the Fund Rate	Limited to R98 420 per beneficiary per year	Where the loss of the limb was due to a trauma. These costs do not add up to any other prostheses limits

5.5	Counselling sessions with a psychologist or social worker	100% of the Fund Rate	6 sessions per person	Available to the registered beneficiaries in the member-family indirectly affected by the traumatic event
6.	**Screening and Preventative Care Benefits**			
	These benefits are not paid from the Primary Care Benefits			
6.1	Pharmacy Screening Benefit (for adults)	100% of the agreed rate	1 or all these tests conducted at the Fund's Network provider, per beneficiary per year	Member must have the testing done at an accredited provider in the Network: • Blood glucose test • Blood pressure test • Total serum cholesterol test • BMI
6.2	Children's screening benefit 	100% of the agreed rate	1 or all these tests conducted at the Fund's Network provider, per beneficiary per year	▪ Basic hearing and dental screening ▪ Body mass index for children between the ages of 2 up until their 18th birthday (including counselling) ▪ Head circumference for children between 2 and 5 years old • Blood pressure for children between the ages of 3 up until their 18th birthday Health behaviour and milestone tracking for children between the ages of 2 up until their 18th birthday
6.3	Screening benefits for Seniors	100% of the Fund Rate	Limited to a group of tests provided by the Fund's DSP (where applicable)	• Group of specific age-appropriate screening tests for persons 65 years and older. • One additional comprehensive screening assessment per beneficiary per year at a Network GP for at risk persons
	Other Screening Benefits			
6.3	Pap Smear	100% of the Fund Rate	1 every 3 years One every year	Benefit for LBC/PAP smear Count started in 2020 For HIV positive beneficiaries or beneficiaries with an abnormal Pap smear result Subject to clinical entry criteria and authorisation
6.4	Mammogram	100% of the Fund Rate	1 paid every 2 years 1 every year Once off	Mammogram (inclusive of ultrasound) Count started in 2020 Mammography or MRI breast screening

				BRCA testing for at risk beneficiaries. Subject to clinical entry criteria and authorisation
6.5	Faecal Occult Blood Test (or faecal immunochemical test) Colonoscopy for at risk members, or those with a positive test result	100% of the Fund Rate	1 of the listed tests every 2 years for all beneficiaries between the ages of 45 and 75 1 per year	Faecal occult blood test, or immunochemical test Count started in 2020 Subject to clinical entry criteria
	Preventative Care Benefits			
6.6	Seasonal flu vaccination	100% of the Fund Rate	1 vaccination per beneficiary per year	For <u>all beneficiaries</u> registered on the Fund
6.7	Pneumococcal vaccination	100% of the Fund Rate	Once per lifetime	One of two specific pneumococcal vaccinations for high-risk members in the following categories: • Members registered on the CIB for cardiac failure or cardiomyopathy; and • Persons over the age of 65.
6.8	Baby and Child immunisations	100% of the Fund Rate		• Standard immunisations for children up to the age of 12 years; • MMR vaccine for measles, mumps, and rubella (German measles) Based on Department of Health Protocols (excluding HPV vaccine)
7.	**Health Care Programmes**			
	These benefits are not paid from the Primary Care Benefits			
7.1	Mental Health Care Programme Out of hospital disease management, for the treatment of acute and / or episodic major depression	100% of the Fund Rate	Unlimited according to basket of non-PMB GP-related care	1. From Premier Plus GPs for non-PMB, GP-related care 2. Care for Cognitive Bahavioural Therapy provided by Premier Plus GP. Includes digital therapeutics (if referred by the GP) 3. Members are registered on the Programme by referral from the Premier Plus GP
7.2	Diabetes Disease Management Programme or Cardio Care Programme	100% of Fund Rate	Unlimited according to basket of non-PMB GP-related care	1. From Premier Plus GPs for non-PMB, GP-related care 2. Subject to registration on the Fund's Chronic Illness Benefit for the related conditions 3. Subject to registration on the Programme by referral from the Premier Plus GP

8	***PRIMARY CARE (DAY-TO-DAY) BENEFITS*** ***Subject to payment from Medical Savings Account***			
	Preamble Unless stated otherwise, Primary care (day-to-day) benefits are first paid at 100% of the Fund Rate from the Medical Savings Account (MSA) (which comprises 10% of the total annual medical contribution) until the advance credit has been fully utilised in any one financial year. Once the MSA is exhausted, the Primary Care benefits are paid as described in 8.1 to 8.19 below			
8.1	Acute, homeopathic or naturopathic medicine *Includes medicine, material for injections and vaccinations prescribed by a person legally entitled to prescribe;* *Includes medicine dispensed to outpatients* Implanon (contraceptive device)	100% of the Fund Rate	Limited to: M R6 490 M+1 R9 630 M+2 R10 990 M+3 R12 670 M+4+ R14 130 per year	1. Do not include medicines and materials for injections supplied or administered in hospital or a nursing home 2. If a co-payment is applied to the medicine dispensed by the pharmacy, the member must settle the amount due directly with the dispensing pharmacy Paid from available Medical Savings only
8.2	General Practitioner, Medical Specialists, Homeopaths, Naturopaths, and registered Private Nurse practitioner consultations (includes benefits for tele- and virtual consultations) and non-surgical procedures *Includes the cost of vaccinations and injection material, e.g., the cost of mumps, measles, and rubella (MMR) vaccinations by registered nurses*	100% of agreed rate or up to the Fund Rate	Limited: M R3 350 M+1 R5 440 M+2 R6 490 M+3 R7 010 M+4+ R8 170 per year	1. PMB or DTPMB-related treatment and in hospital visits and care not included in this benefit 2. If services of non-Network providers are used, paid up to the Fund Rate only 3. Includes services and fees charged for outpatient consultation services
8.3	Basic Radiology or pathology (out of hospital) *Including Point of Care Pathology services*	100% of agreed rate or up to the Fund Rate	Limited: M = R10 000 M+1 = R12 000 M+2 = R13 000 M+3 = R14 000 M+4+=R15 000	Paid from Medical Savings Account and Primary Care Benefits
8.4	Self-medication (Over the Counter (OTC)) medicine	100% of cost	Limited to R330 per script per beneficiary per day	1. Limited to medicine which a pharmacist is entitled to prescribe 2. Paid from the Medical Savings Account
	PARAMEDICAL AND ASSOCIATED SERVICES – includes benefits for tele- and virtual consultations			
8.5	Acupuncture	80% of the Fund Rate	Limited to R2 090 per family per year	

8.6	Chiropractic treatment	80% of the Fund Rate	Limited to R3 870 per family per year	1. Includes the cost of the treatment and x-rays 2. The benefit shall not exceed the Fund Rate for a consultation with a General Practitioner
8.7	Dietetics	80% of the Fund Rate	Limited to R1 360 per family per year	
8.8	Non-surgical prostheses	80% of the cost	Limited to R3 770 per family per year	1. Includes benefits for prostheses for which a benefit is not provided elsewhere in these Rules
8.9	Audiology or speech therapy	80% of the Fund Rate	Limited to R3 770 per family per year	
8.10	Occupational therapy	80% of the Fund Rate	Limited to R3 770 per family per year	
8.11	Physiotherapy or Biokinetics	80% of the Fund Rate	Limited to R3 770 per family per year	
8.12	Registered private nurse practitioners *Includes private nursing, frail care or hospice treatment prescribed by a medical practitioner*	80% of the Fund Rate	Limited to R32 040 per family per year	1. Subject to preauthorisation 2. Excludes general care 3. Private nurses must be registered with the South African Nursing Council
8.13	Podiatry or Chiropody	80% of the Fund Rate	Limited to R2 510 per family per year	Treatment must be prescribed by a medical practitioner
8.14	Clinical psychology	80% of the Fund Rate	Limited to R10 470 per family per year	
	DENTISTRY			
8.15	Basic Dentistry	100% of the Fund Rate	Limited to: M R4 712 M+1 R5 863 M+2 R7 224 M+3 R8 900 M+4+ R10 365 per year	Paid from Medical Savings Account and Insured Benefits
8.16	Specialised Dentistry *Includes inlays, crowns, bridges, study models, metal base dentures and the repair thereof, oral medicine, periodontics, orthodontics, and prosthodontics and osseo-integrated implantology*	100% of the Fund Rate	Limited to: R17 400 per family, with a sub-limit of R10 000 per beneficiary per year	1. Paid from Insured Benefits 2. Orthodontics subject to approval
	OPTICAL			
8.17	Eye and tonometry tests	100% of the Fund Rate	1 eye test and one tonometry test	

			per beneficiary per year	1. Paid from the Medical Savings Account and Insured Benefits limit 2. Accrues to the Insured limits even if paid from MSA 3. Eye tests and tonometry must be performed by a registered Optometrist 4. A sub-limit of R1 880 applies per frame in every two-year cycle 5. Sunglasses, spectacle cases, solutions and kits for contact lenses are excluded
8.18	Spectacles or contact lenses		Single Member: R5 760 Family: R11 730 Limits apply in a 2-year cycle	
	PREVENTATIVE SCREENING / CARE			
8.16	HPV Screening *Used as a screening test for female members who receive abnormal results after a cervical cystology screening test (abnormal PAP test)*	100% of the Fund Rate	Limited to R660 per beneficiary per year	1. Subject to payment from the Medical Savings Account
8.17	Smoking cessation	100% of the Fund Rate	Limited to R840 per beneficiary per month	1. Subject to the Medical Savings Account 2. Claims paid from the Medical Savings Account may be reimbursed from the Chronic Medication Benefit, subject to a negative nicotine test result

LEGEND

Agreed rate	The rate of payment for services, as negotiated with a specific provider or group of providers
Cost	A fee charged outside the Fund Rate or Agreed Rate
DSP	Designated Service Providers for Prescribed Minimum Benefits: • KeyCare Hospital Network • Facilities in the Day Surgery Network for procedures listed in Annexure F of these Rules; • The Discovery Health Network of General Practitioners; • General Practitioners in the KeyCare GP Network • Specialists who agreed to accept the Premier A or Premier B rates and all Specialists participating in the KeyCare Specialist Network • Premier Plus GPs provide services in terms of the Fund's Health Care Management Programmes • Pharmacies in the Oncology Pharmacy Network • ER24 for medical emergency transportation • Other providers with whom the Fund has negotiated Agreed Rates for other specific PMB services or care, as stipulated in Annexures B and D
DTPMBs	A list of 270 Diagnosis and Treatment Pairs covered under the PMBs

Fund Rate	The Rate determined from time to time by Engen Medical Benefit Fund for the reimbursement of claims, based on the Discovery Health Rate in the absence of any other agreed rate with any service provider, or as agreed to between the Fund and the provider. These rates may be based on Alternative Reimbursement Models
Fund Medicine Rate	The Single Exit Price plus dispensing fee for medicine that is on the formulary for CDL conditions. Where non-formulary medicine is used voluntarily, the Fund will pay up to a Chronic Drug Amount. For non-PMB Additional Disease List conditions, a condition-specific Chronic Drug Amount (CDA) will apply, if relevant. In all other cases, the Fund Medicine Rate is the Single Exit Price plus the applicable dispensing fee.
ICD-10	International Statistical Classification of Disease and Related Health Problems – version 10: healthcare professionals must provide an ICD-10 diagnosis with every claim submitted to the Fund
Network Provider	A provider with whom the Fund has agreed certain rates and clinical outcomes. If the member makes use of the services of these providers, benefits will be paid in full. The Fund has several Network providers for the various internal medical items and/or devices
PMB formulary	A preferred list of medicines for the treatment of the 26 listed PMB chronic conditions. In creating this list, safety, effectiveness, and possible side effects are considered before considering the cost of the medicine. The list meets the requirements of the applicable Regulations
PMB	Prescribed Minimum Benefits