ANGLO MEDICAL SCHEME
VALUE CARE PLAN
ANNEXURE B3

BENEFITS – Effective 1 January 2027

1 Definitions

The following words or expressions have the following meanings:

1.1 "annual family limit" – the total benefit amount that is available to a member family, in respect of a particular benefit, in any one financial year;

1.2 "beneficiary" – a member, adult dependant or child dependant;

1.3 "chronic condition" – is a medical condition that is a prescribed minimum benefit (PMB) condition as listed in Annexure A to the regulations;

1.3.1 A prescribed minimum benefit (PMB) condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A to the regulations, that includes the diagnosis, medical management and medication to the extent that it is provided for in terms of a therapeutic algorithm as prescribed for the specific chronic condition. This includes the PMB chronic disease list for the following conditions:

Addison's disease, Asthma; Bipolar mood disorder; Bronchiectasis; Cardiac failure; Cardiomyopathy; Chronic renal disease; Chronic obstructive pulmonary disease; Coronary artery

disease; Crohn's disease; Diabetes insipidus; Diabetes mellitus Type 1 and 2; Dysrhythmias, Epilepsy; Glaucoma; Haemophilia; Hyperlipidaemia; Hypertension; Hypothyroidism; Multiple sclerosis; Parkinson's disease; Rheumatoid arthritis; Schizophrenia; Systemic lupus erythematosus; Ulcerative colitis;

1.4 "contracted network service provider" – a service provider who is contracted to Prime Cure to provide healthcare services to members and their registered dependants. (The Scheme shall provide members with an electronic list containing the addresses of the contracted network service providers, and shall update the list from time to time);

1.5 "designated service provider" (DSP) – a healthcare provider contracted by the Scheme as the preferred provider for the diagnosis, treatment and care of one or more PMB conditions;

1.6 "Healthcare Centre" – a facility operated by, or on behalf of Prime Cure. (The Scheme shall provide the member with an electronic list containing the addresses of the Healthcare Centres and shall up-date the list from time to time);

1.7 "medicine formulary" – a list of medicines preferred by Prime Cure;

1.8 "Prime Cure" – a healthcare company registered as Prime Cure Health (Pty) Ltd, which provides healthcare services at

Healthcare Centres and through contracted network service providers and is the Scheme's contracted DSP;

1.9 "Prime Cure agreed tariff" – the cost of a healthcare service, as negotiated and agreed between Prime Cure and a particular service provider;

1.10 "Prime Cure practitioner" – a medical practitioner who practices at a Healthcare Centre; and

1.11 "Single Exit Price" (SEP) – the price of a specific drug, determined annually by the Department of Health.

2 Pro-ration of Benefits

A member or registered dependant who is admitted to the Scheme during the course of a financial year shall have his/her benefits pro-rated.

The benefits to which he/she is entitled will therefore be adjusted in proportion to the period of his/her membership, which will be calculated from the admission date to the end of that financial year.

3 Management Programmes

The following management programmes have been adopted by the Scheme –

3.1 The Hospital Benefit Management Programme – a programme which involves the approval of all hospital events, and on-going monitoring, by or on behalf of the Scheme, of

hospital treatment of all medical conditions;

3.2 Disease /Condition Management Programme – a programme which incorporates evidenced clinical protocols for containing costs and/or on-going review and monitoring of patients with a defined medical condition.

Specific Disease/Condition Management Programmes, which have been adopted by the Scheme are the Prime Cure HIV/AIDS Management Programme and the Prime Cure Oncology Management Programme, Chronic Condition Management;

3.3 If the Scheme has adopted a management programme for a particular condition, the benefit in respect of such condition is subject to pre-authorisation and registration with the relevant management programme.

4 Pre-Authorisation

Where a benefit is subject to pre-authorisation, a beneficiary must obtain authorisation from Prime Cure prior to obtaining the relevant health service to which the benefit relates.

Unless otherwise stated, a beneficiary who fails to obtain such prior authorisation for a PMB condition will, except in the case of a medical emergency condition, be liable for a **30%** co-payment. A member who fails to obtain such prior authorisation will, in the case of a non-PMB, be held liable for the full cost of the services rendered.

5 Benefits

The benefits to which a member is entitled in respect of himself/herself, and each of his/her registered dependants, are set out below.

5.1 PRESCRIBED MINIMUM BENEFITS

A beneficiary is entitled to 100% of the cost of the diagnosis, treatment and care of the PMB conditions contemplated by the Act, provided that any services in relation to PMB conditions are pre-authorised and obtained from a –

5.1.1 a Prime Cure DSP; or

5.1.2 public hospital.

A co-payment will be imposed if a beneficiary voluntarily obtains such services from a provider other than a DSP or a public hospital.

This co-payment will be the difference between the actual cost incurred and the cost that would have been incurred had the service been obtained from a DSP or a public hospital, or is the specified value detailed in the Rule relating to the relevant benefit. No co-payment will be imposed on a member if the service was involuntarily obtained from a provider other than a DSP or a public hospital.

A co-payment as contemplated above will also be imposed in

those instances where a beneficiary voluntarily declines a medicine formulary drug and chooses to use another drug instead.

5.2 ALCOHOL AND DRUG DEPENDANCY

Subject to PMB regulations, pre-authorisation by Prime Cure and the DSP, a beneficiary is entitled to the following:

5.2.1 Hospitalisation

Subject to the annual family limit for hospitalisation, a beneficiary is entitled to 100% of the Prime Cure agreed tariff with the DSP, or the actual cost, if lower, for hospitalisation for alcohol or drug dependency, per annum, subject to PMB regulations.

5.2.2 Professional Services Out of Hospital

Subject to PMB regulations and the annual family limit for hospitalisation, a beneficiary is entitled to 100% of the Prime Cure agreed tariff with the DSP, or the actual cost, if lower, if provided at a DSP, unless involuntarily obtained from a non-DSP.

5.3 AMBULANCE SERVICES

Subject to pre-authorisation by Prime Cure, a beneficiary is entitled to 100% of the Prime Cure agreed tariff or the actual cost, if lower, of emergency transport and other ambulance services, provided such service is obtained from a contracted network service provider, unless involuntarily obtained from a non-DSP or in the case of a medical emergency condition. In such events,

a member must notify Prime Cure the following day of the emergency event. In the event of the voluntary use of a non-DSP provider, a beneficiary will be liable for a **30%** co-payment.

A member will be required to pay the full cost of a non-medically justifiable use of an ambulance service.

5.4 AUXILIARY HEALTH SERVICES

5.4.1 Subject to pre-authorisation, and referral by a Prime Cure practitioner or contracted network service provider, a beneficiary is entitled to 100% of the Prime Cure agreed tariff, limited collectively to the out of hospital allied services listed below, to a sub-limit of **R3 605** per family per annum and a maximum limit of **R2 405** per beneficiary -

5.4.1.1 audiology;
5.4.1.2 dietician services;
5.4.1.3 clinical psychology;
5.4.1.4 speech and occupational therapy;
5.4.1.5 podiatry services;
5.4.1.6 physiotherapy; and
5.4.1.7 social services.

A co-payment of **30%** of the Prime Cure agreed tariff for services will apply to those members who self-refer to a non-Prime Cure practitioner or contracted network service provider.

5.5 BLOOD TRANSFUSIONS

Subject to pre-authorisation, the annual family limit for hospitalisation and referral by a Prime Cure practitioner or contracted network service provider, a beneficiary is entitled to 100% of the Prime Cure agreed tariff of blood transfusions and is limited to **R21 625** per family per annum, except in the case of PMB conditions.

5.6 CONSULTATIONS AND VISITS

5.6.1 Specialist Consultations and Visits Out of Hospital

Subject to PMB regulations, referral by a contracted network service provider and pre-authorisation prior to a specialist visit, a beneficiary is entitled to 100% of the Prime Cure agreed tariff, or the actual cost, if lower, of consultations and procedures performed out of hospital by a designated specialist, according to a Prime Cure approved list of specialist codes and treatment protocols, subject to the following limitations:

5.6.1.1 Five consultations per family per year, inclusive of the cost of any prescribed medication, subject to a maximum of three per beneficiary, and limited to **R 4 6 4 0** per family per annum for non-PMB visits;

5.6.1.2 Cost of involuntary use of a non- designated provider will be paid at the Prime Cure agreed tariff; and

5.6.1.3 Failure to obtain pre-authorisation will result in a **30%** co-payment.

5.6.2 **General Practitioner Consultations and Visits Out of Hospital at a contracted network service provider**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff, or the actual cost if lower, of consultations and procedures performed out of hospital, by general practitioners provided that the service is obtained at a registered Healthcare Centre or at a contracted network service provider with the following limitations:

5.6.2.1 All visits after the 4th consultation per beneficiary per annum must be pre-authorised by the member or provider and will be subject to clinical triage. Failure to obtain authorisation for a consultation for a PMB condition will result in the member being held liable for a **30%** co-payment. Failure to obtain authorisation for a non-PMB condition will result in the member being held liable for the full cost of the consultation.

5.6.2.2 **Immunisation** –

Subject to Prime Cure protocols, a beneficiary is entitled to 100% of the

Prime Cure agreed tariff, or the actual cost if lower, of:

5.6.2.2.1 One flu vaccine per beneficiary per annum.

5.6.2.2.2 Subject to PMB regulations, a COVID-19 vaccine and the administration fee.

5.6.2.3 **Virtual consultations** – a beneficiary is entitled to unlimited phone or video consultations through Prime Cure Virtual Clinics. An assessment is done by a nurse first and then referred if necessary. This is available through either a Prime Cure Doctor or in a Dis-Chem clinic.

5.6.3 **General Practitioner Consultations and Visits Out of Hospital at a non-contracted network service provider**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff, or the actual cost, if lower, of consultations and visits out of hospital received from general medical practitioners, subject to authorisation to be obtained on or before the first working day after the event. This benefit is subject to a co-payment of **30%** per visit and a limit of **R1 330** per consultation and/or visit, including related expenses, excluding facility fees.

The provider must be paid at point of service, thereafter, the beneficiary may claim the costs from Prime Cure. It is limited to one consultation/visit per beneficiary and limited to a maximum of two visits per family per annum.

5.6.4 General Practitioner Consultations and Visits Out of Hospital, excluding facility fees, in the case of an emergency are unlimited and without co-payment if the episode meets the requirements of the Prime Cure definition of a medical emergency condition. Authorisation must be obtained on or before the first working day after an event by the member or the provider.

5.6.5 **General Practitioner and Specialist Consultations and services In Hospital**

Subject to PMB regulations and pre-authorisation by Prime Cure and the annual family limit for hospitalisation, a beneficiary is entitled to 100% of the Prime Cure agreed tariff, or the actual cost, if lower, of consultations and visits in a public hospital or Prime Cure contracted private hospitals, by general practitioners, nurse practitioners and medical specialists.

5.6.6 **Allied Health Services in Hospital**

5.6.6.1 Subject to the annual family limit for hospitalisation, pre-authorisation, evidence-based protocols and case management, allied services in hospital for physiotherapy, dietetics, occupational therapy, speech therapy, podiatry and social workers are subject to the Allied Health Services in hospital sub-limit of **R10 555** per family per annum;

5.6.6.2 Benefits for non-PMB psychiatric conditions are limited to five days per admission in a public hospital psychiatric facility, subject to the annual family limit for hospitalisation, pre-authorisation, subject to the Allied Health Services sub-limit of **R10 555** per family per annum. Benefit for sleep therapy is excluded.

5.6.6.3 Benefits for PMB psychiatric conditions are limited to:

5.6.6.3.1 a maximum of twenty one days in a public hospital psychiatric facility or Prime Cure approved network facility; or

5.6.6.3.2 up to 15 out of hospital consultations.

5.6.7 **Nurse Practitioner Consultation at a Pharmacy Wellness Clinic**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff, for consultations with a nurse practitioner for minor illness at a Prime Cure contracted Network Pharmacy Wellness Clinic, limited to a maximum of **R365** per visit and **R730** per family per annum.

5.7 DENTAL

5.7.1 **Conservative Dentistry**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff of the following out of hospital dental procedures performed by a general dental practitioner at a Healthcare Centre or by a contracted network service provider, subject to Prime Cure dental protocols and limited to one consultation per beneficiary per annum if clinically appropriate:

One consultation for a full mouth examination per beneficiary per annum – subject to list of benefit codes

5.7.1.1 Primary extractions subject to pre-authorisation where five or more extractions are required, except in the case of an emergency; Extractions (Only if clinically necessary).

5.7.1.2 Four composite (white) or amalgam fillings and pre-authorisation is required for five or more restorations (only anterior covered);

5.7.1.3 Composite fillings for anterior teeth only to a maximum of four fillings where-after pre-authorisation needs to be obtained;

5.7.1.4 Two sets of x-rays inclusive of one intra oral radiograph. Additional x-rays to a maximum of four require pre-authorisation;

5.7.1.5 Emergency root canal treatment subject to a list of approved codes;

5.7.1.6 Examination and treatment of emergency pain and sepsis subject to a list of approved codes;

5.7.1.7 One preventative treatment per beneficiary per annum inclusive of fluoride treatment, cleaning, scaling and polishing. Authorisation needed for children under the age of 12; and

5.7.1.8 Dental emergency out of network visits are limited to one event per beneficiary per year to cover emergency pain management, sepsis and extractions paid at the Prime Cure tariff.

5.7.2 **Specialised Dentistry – no benefits except for:**

5.7.2.1 Dentures. A family is entitled to 80% of the Prime Cure agreed tariff of two sets of acrylic dentures per family every 36 months for members over the age of 21 when provided by a general dental practitioner at a Healthcare Centre or by a contracted network service provider.

The balance of **20%** shall be the co-payment and shall be paid to the dentist at the time of placing an order for dentures.

5.7.2.2 Denture repairs. A family is entitled to two repairs within a 12-month cycle six months after receiving a denture.

5.7.3 **Dental Hospitalisation**

Subject to the annual family limit for hospitalisation and pre-authorisation by Prime Cure, a beneficiary is entitled to 100% of the Prime Cure agreed tariff of hospital admissions, when provided by a public hospital or a Prime Cure contracted private hospital, for the following dental and surgical procedures:

5.7.3.1 Children under seven years;

5.7.3.2 Impacted 3rd molars subject to PMB regulations; and

5.7.3.3 Trauma.

5.7.4 **Dental Medication – Acute**

5.7.4.1 Limited to the Prime Cure formulary;

5.7.4.2 Prescribed and dispensed by an approved Prime Cure designated service provider.

5.8 **HIV/AIDS (subject to Rule 5.1.2)**

Subject to registration on the Prime Cure HIV/AIDS Management Programme, a beneficiary is entitled to:

5.8.1 **Services Out of Hospital**

5.8.1.1 100% of the Prime Cure agreed tariff, or the actual cost, if lower, of services relating to the treatment or management of HIV/AIDS at a Prime Cure DSP; and

5.8.1.2 Prescribed medicines in accordance with the Prime Cure medicine formulary for the treatment of HIV/AIDS.

5.8.1.3 HIV screening test at a Prime Cure contracted Network Pharmacy Clinic.

5.8.1.4 HIV test at 100% of Prime Cure Tariff or the actual cost, if lower, subject to the Prime Cure approved pathology codes for pathology services rendered by a registered pathologist or medical technologist.

Should a beneficiary elect not to participate in the Prime Cure HIV/AIDS Management Programme, benefits detailed in Rules 5.8.1, 5.8.2 and 5.11.3.1 below, will be subject to Rule 5.1 above.

5.8.2 **Services In Hospital**

5.8.2.1 Subject to Rule 5.1 and admission to a DSP hospital only, subject to registration on the HIV/AIDS programme.

5.9 **HOSPITALISATION**

5.9.1 **General**

Subject to a limit of **R217 000** per family per annum and subject to a private hospital sub limit for specialist services in hospital of **R93 700** per family per annum, a beneficiary is entitled to 100% of the Prime Cure agreed tariff as negotiated between Prime Cure and the service provider concerned, in respect of all services received in public hospitals or Prime Cure contracted private hospitals. Such services must, however, be referred by a Prime Cure practitioner or contracted network service provider or be provided by a contracted network service provider.

5.9.2 **Referral and Pre-authorisation**

All hospital admissions are subject to referral by a Prime Cure practitioner and to pre-authorisation by Prime Cure, except in the case of an admission for a medical emergency condition.

In such an event, a member must notify Prime Cure within 24 hours after the emergency or the first working day after the admission. Elective procedures need authorisation before the event. In the event that no authorisation for non-emergency procedures was obtained, a member will be required to pay a co-payment of **R2 405** per admission.

5.9.3 **Ward fees**

Subject to PMB regulations and the annual family limit for hospitalisation, a beneficiary is entitled to 100% of the Prime Cure agreed tariff, as negotiated between Prime Cure and the hospital concerned subject to case management, for:

5.9.3.1 general ward fees;

5.9.3.2 high care and intensive care unit fees.

5.9.4 **Ward and Theatre Drugs and Appliances**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff, as negotiated between Prime Cure and the hospital concerned, for ward and theatre drugs and appliances that are prescribed and used while the beneficiary is hospitalised, subject to PMB regulations, case management and the following limits –

5.9.4.1 In the case of prescribed drugs, the Prime Cure agreed tariff for such drugs and the annual family limit for hospitalisation;

5.9.4.2 Internal surgical prosthesis sub-limit of **R37 930** per family per annum subject to the annual family limit for hospitalisation and pre-authorisation; and

5.9.4.3 In the case of "To Take Out" (TTO) medicine, a limit of seven days' supply is allowed on discharge, subject to the annual family limit for hospitalisation and Prime Cure medicine formulary.

5.9.5 **Theatre Fees and Material**

Subject to the annual family limit for hospitalisation, a beneficiary is entitled to 100% of the Prime Cure agreed tariff, as negotiated between Prime Cure and the hospital concerned, for theatre fees, labour ward charges, dressings and materials used in theatre, subject to case management.

5.9.6 **Endoscopy**

Subject to PMB regulations, pre-authorisation and referral, a beneficiary is entitled to 100% of the Prime Cure agreed tariff subject to the annual family limit for hospitalisation for an endoscopic procedure if performed in a Prime Cure hospital contracted to perform endoscopic procedures. Procedures performed in a day hospital will be covered subject to the annual limit for hospitalisation.

5.10 MATERNITY (subject to PMB regulations)

All maternity related costs are subject to the annual family limit for hospitalisation.

5.10.1 Ante-natal Consultations and Post-natal Care at a contracted network service provider out of hospital

A beneficiary is entitled to a 100% of the Prime Cure agreed tariff, or the actual cost, if lower, of ante- and post-natal consultations and visits performed out of hospital, by general practitioners or nursing practitioners, provided that the service is obtained at a registered Healthcare Centre or a contracted network service provider.

5.10.2 Ante-natal vitamins

Subject to the medicine formulary list, a qualifying beneficiary is entitled to 100% of the Prime Cure agreed tariff of folic acid to a maximum of nine repeat prescriptions per pregnancy, when prescribed by a Prime Cure practitioner at a Healthcare Centre or contracted network service provider and supplied by a network service provider or DSP pharmacy.

5.10.3 Specialist Ante-natal Consultations and Post-natal Care out of hospital

A beneficiary is entitled to 100% of the Prime Cure agreed tariff, or the actual cost, if lower, of ante- and post-natal consultations and visits performed out of hospital, by a specialist subject to a maximum of

three visits per pregnancy per annum and two, 2 dimensional ultrasound scans per pregnancy subject to referral by a Prime Cure practitioner.

Should a 3 dimensional ultrasound scan be obtained, a co-payment equal to the difference between the Prime Cure agreed tariff for a 2 dimensional ultrasound scan and the 3 dimensional ultrasound scan will apply.

Ultrasound scans must be performed by a Radiologist.

Subject to authorisation, one routine foetal anomaly scan per pregnancy performed between 18 and 24 weeks gestation by an appropriately qualified healthcare provider.

Should the beneficiary voluntarily use a non-designated provider, a co-payment equal to the difference between the Prime Cure agreed tariff of the DSP and the tariff of the non-DSP, will apply.

Failure to obtain pre-authorisation will result in a **30%** co-payment.

5.10.4 **Confinement in Hospital**

Subject to authorisation, a beneficiary is entitled to 100% of the Prime Cure agreed tariff as negotiated between Prime Cure and the service provider concerned, in respect of all services received in a public facility or Prime Cure DSP only. Such services

must, however be referred by a Prime Cure practitioner or contracted network service provider or be provided by a contracted network service provider.

5.11 MEDICINES

A beneficiary is entitled to one month's supply in respect of medicines obtained on a prescription, for every prescription or repeat thereof.

5.11.1 Acute Medication

Subject to the medicine formulary list, a beneficiary is entitled to 100% of the Prime Cure agreed tariff of acute medication and injection material, provided that such medication or material is supplied by a Healthcare Centre or contracted network service provider. The medication must be prescribed by a Prime Cure practitioner, dentist or nursing sister at a Healthcare Centre, or by a contracted network service provider.

5.11.2 Contraceptive medication

Subject to the medicine formulary list and the annual family limit for hospitalisation, a qualifying beneficiary is entitled to 100% of the Prime Cure agreed tariff of contraceptive medication to a value of **R2 930** per annum, when prescribed by a Prime Cure practitioner at a Healthcare Centre or contracted network service provider and supplied by a network service provider or DSP pharmacy.

5.11.3 Pharmacist Advised Therapy (PAT)

Subject to the Prime Cure formulary a beneficiary may obtain medicines from a Prime Cure accredited network service provider/DSP pharmacy, without a doctor's prescription. The benefit in respect of the cost of such medicines is limited to **R130** per prescription, and a maximum of three prescriptions per beneficiary and **R390** per annum.

5.11.4 **Chronic Medication**

5.11.4.1 **PMB Conditions**

Where a PMB condition includes chronic medication, a beneficiary will be entitled to 100% of the medicine formulary provided the beneficiary is registered on the condition management programme and the medication is prescribed by a Prime Cure practitioner and obtained from a DSP and pre-authorised by Prime Cure.

A beneficiary will also be entitled to 100% of the Prime Cure price of the medicine if involuntarily obtained from a provider other than a DSP; and

5.11.4.2 if voluntarily obtained, the member makes a co-payment equal to the difference between the actual cost incurred and the cost that would have been incurred had the drug been obtained from a DSP or where the member had knowingly used a non-formulary drug.

5.11.4.3 **Non-PMB Conditions**

No benefit.

5.11.4.4 **Medicine obtained on a specialist prescription**

Subject to the medicine formulary, a beneficiary is entitled to 100% of the Prime Cure agreed tariff of medication prescribed by a specialist, provided that such medication or material is supplied by a Prime Cure Healthcare Centre or contracted pharmacy network service provider. Unless a PMB, the cost of such medication is subject to the specialist consultations and visits out of hospital limit.

5.12 ONCOLOGY

Subject to registration with the Prime Cure Oncology Programme, as well as his/her annual family limit for hospitalisation, unless a PMB condition, a beneficiary is entitled to 100% of the Prime Cure agreed tariff at a state facility or at a contracted network service provider in respect of oncology services subject to referral by a Prime Cure practitioner or contracted network service provider.

5.13 OPTICAL SERVICES

A beneficiary is entitled to 100% of the Prime Cure agreed tariff cost of the following conservative or basic optical service, provided by an optometrist at a contracted network service provider -

5.13.1 Eye examinations – subject to a limit of one examination per beneficiary per annum; and

5.13.2 Spectacles that are untinted, subject to selected frames approved by Prime Cure and single vision or bi-focal lenses prescriptions as per Prime Cure clinical entry criteria and norms. This benefit is subject to a limit of one pair of spectacles per beneficiary every two years.

5.14 PATHOLOGY

5.14.1 Pathology Services Out of Hospital

A beneficiary is entitled to 100% of the Prime Cure negotiated cost for services rendered out-of-hospital provided such services are according to Prime Cure approved pathology codes and requested and provided by a Prime Cure practitioner, or a contracted network service provider.

5.14.2 Pathology Services In Hospital

Subject to PMB regulations and the annual family limit for hospitalisation and a sub-limit of **R24 615** per family for pathology, a beneficiary is entitled to 100% of the Prime Cure agreed tariff for services rendered in hospital, provided such services are according to Prime Cure approved pathology codes, or the actual cost, if lower, of pathology services requested by a Prime Cure practitioner or contracted service provider and rendered at a DSP.

5.14.3 **Pathology Services In and Out of hospital for PMB Conditions**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff for services rendered in and out of hospital, provided such services are according to Prime Cure approved pathology codes of pathology services that are requested by a Prime Cure practitioner or contracted service provider.

5.14.4 **Cancer Screening Tests**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff for one PAP smear or one Prostate Specific Antigen (PSA) screening test, per annum, at a Prime Cure facility.

5.15 **RADIOLOGY**

5.15.1 **Basic Radiological Services Out of hospital**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff or services rendered out of hospital provided such services are according to Prime Cure approved radiology codes and requested and provided by a Prime Cure practitioner, or a contracted network service provider.

Basic radiology requested by a specialist will only be covered if the member was referred by a Prime Cure designated provider and authorisation was obtained for the specialist consultation.

Subject to authorisation, a female beneficiary age 40 or older is entitled to one mammogram per annum subject to the in and out-of-hospital specialised radiology sub limit.

5.15.2 **Basic Radiological Services In hospital**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff for services rendered in hospital provided such services are according to Prime Cure approved radiology codes and requested and subject to the annual family limit for hospitalisation.

5.15.3 **Specialised Radiology In and Out of hospital**

A beneficiary is entitled to 100% of the Prime Cure agreed tariff for services rendered in and out of hospital, provided such services are according to Prime Cure approved specialised radiology codes that are requested by a Prime Cure practitioner or contracted network service provider, subject to a combined sub limit of **R24 615** per family per annum for in and out-of-hospital specialised radiology, inclusive of MRI's and CT scans, and the annual family limit for hospitalisation.

5.16 RENAL DIALYSIS

Subject to PMB regulations and pre-authorisation and registration with Prime Cure, and the annual family limit for hospitalisation, a beneficiary is entitled to 100% of the price of Prime Cure agreed tariff, or actual cost if lower, of services for Haemodialysis and Peritoneal Dialysis provided that such services are referred by a Prime Cure practitioner or contracted network service provider subject to the Department of Health Guidelines and provided by a state facility.

5.17 TRANSPLANTS

Subject to pre-authorisation by Prime Cure, as well as the annual family limit for hospitalisation, a beneficiary is entitled to 100% of the Prime Cure agreed tariff, or the actual cost, if lower, of services relating to organ transplants, provided such services are referred by a Prime Cure practitioner or contracted network service provider and obtained in a public hospital subject to the Department of Health Guidelines and provided by a state facility.

5.18 WELLNESS

A beneficiary is entitled to 100% of the Scheme Reimbursement Rate (SRR), of one screening benefit group of tests consisting of a blood glucose test, a blood pressure test, a cholesterol test and a Body Mass Index (BMI) if performed at a Dis-Chem pharmacy or Clicks pharmacy.

5.19 EXTERNAL PROSTHESIS

Subject to PMB regulations and pre-authorisation by Prime Cure, a beneficiary is entitled to an external prosthesis limit of **R6 000** per annum whether rendered in- or out-of-hospital. This benefit is not subject to the overall annual hospital limit.

External prostheses include, but are not limited to, artificial limbs, breast prostheses, ocular prostheses and other externally worn prosthetic devices approved by the Scheme.

The external prosthesis must be medical necessary and supported by appropriate clinical motivation where requested by the Scheme.

Repair or replacement of an existing external prosthesis shall be funded from the available benefit where clinically necessary and, in the opinion of the Scheme, is more cost-effective than replacement.

Cosmetic enhancement, elective upgrades, accessories and items not considered medically necessary are excluded from benefit cover.

6. THIRD PARTY LIABILITY

Subject to PMB regulations, a beneficiary is entitled to 100% of the SRR, or the actual cost, if lower, of relevant health care services obtained by a member when involved in an incident which is covered by any statutory compensation provision or, in respect of which, the member has a civil claim against a third party, subject to the member agreeing, by way of a signed undertaking, to

reimburse the Scheme the amount of such benefits paid by the Scheme from any payment received in respect of medical treatment costs made by the statutory body or third party.