PRIMARY OPTION BENEFITS
(Effective 1 January 2025)

DEFINITIONS

The **Scheme Rate** is defined as the rate at which claims are reimbursed, as approved by the Board of Trustees.

Designated Service Provider ('DSP') is defined as a network of providers appointed by the Scheme as preferred providers to provide members with diagnosis, treatment and care in respect of one or more PMB conditions.

The Scheme's Designated Service Providers are:

- The Momentum Primary Healthcare Network for all Primary health care needs (GP, Dentistry, Optometry, Medication etc.)
  - The Momentum Specialist Network
  - The Momentum pharmacy network for all medication and is inclusive of all Mediscor-enabled pharmacies
  - The Pick n Pay Medical Scheme Primary Hospital network, inclusive of the hospital groups listed below:
    - Life Healthcare, where fees have been negotiated on behalf of the Scheme
    - Mediclinic, where fees have been negotiated on behalf of the Scheme
    - State Hospitals
  - The Independent Clinical Oncology Network ('ICON') is a DSP for the provision of oncology benefits
  - ER24 for the provision of emergency medical services only

The **Agreed Rate** is defined as the fee for any health care service, which has been determined by the Board of Trustees following negotiation with a network of service providers.

The **Medicine Reference Price ('MRP')** is the maximum price that the Medical Scheme will pay for specific categories of medicines for which generic and or therapeutic product(s) exist.

Dispensing Fee is the maximum fee, excluding VAT, charged to evaluate a script, prepare the medication and advise the patient.

BENEFITS APPLICABLE TO THE PRIMARY OPTION

The Benefits applicable to the Primary Option, in terms of Rule 16 are as set out below.

Notwithstanding any other provisions in these Rules, the Scheme will provide, in State Hospital facilities or at a Designated Service Provider, all Members and Dependants with cover for the Prescribed Minimum Benefits at 100% of the cost. PMB Admissions will accrue to; but are not subject to; the Overall Annual Limit of R1 531 000 per family per annum.

Voluntary treatment for all elective procedures rendered at an institution other than the DSP Hospitals appointed by the Scheme, shall be subject to a co-payment of 30% of the costs associated with the admission. In the event of emergencies, this ruling would not be applicable for the duration of stabilising the patient; thereafter the patient must be transferred to a DSP.

Should the service prove to be unavailable at any of the Designated Service Providers within reasonable proximity or within a reasonable timeframe, the service will be considered to have been obtained on an involuntary basis and PMB benefits will be paid in full subject to the prevailing Public Hospital protocols.

Dispensing fees will be reimbursed at the rate agreed with the Momentum Pharmacy Network. The difference between dispensing fees at a non-network and a network pharmacy will be payable by the Member.

TABLE 1: HOSPITALISATION BENEFITS

The benefits in Table 1 are for hospitalisation and are subject to an Overall Annual Limit of R1 531 000 per family per annum.

In the event of hospitalisation, the Member is required to obtain compulsory Pre-authorisation. Failure to obtain authorisation at least 48 hours prior to being hospitalised, could result in an R1 000 co-payment being imposed. A member is not required to obtain Pre-authorisation for hospital admission in the case of an emergency. However, in such an instance, the Member must notify the Scheme's provider, Momentum Health Solutions, of the admission within 48 hours thereafter.

BENEFIT	BENEFIT AMOUNT	ANNUAL LIMIT
Statutory Prescribed Minimum Benefits (PMBs)	100% of Cost	In and Out-of-Hospital procedures and treatment rendered by State Hospitals or DSP is unlimited as per the Regulations, subject to Pre-authorisation and the application of Clinical and Funding Protocols
Hospitalisation State Hospitals Private hospitals (excluding rehabilitation) Ward & Theatre Fees	 100% of UPFS or cost, whichever is the lower 100% of Agreed Rate	Subject to an Overall Annual Limit of R1 531 000 **per family**. PMB admissions accrue to, but are not subject to this limit. Benefits for admission to private hospitals are subject to Pre-authorisation, Managed Care Protocols and utilisation of the DSP hospitals appointed by the Scheme. In the event that non-DSP hospitals are voluntarily utilised, the member will be liable for 30% of the costs associated with the admission. Benefits for admission to hospitals are subject to Pre-authorisation with the Scheme's Managed Care Provider at least 2 working days prior to admission or within 48 hours in the case of emergencies. Failure to obtain authorisation could result in a R1 000 co-payment per admission.
Medicines dispensed in hospital and upon discharge from hospital	100% of SEP & Agreed Dispensing fee, subject to Medicine Reference Pricing	To take out medication (TTOs) limited to 7 days' supply and are subject to the medicine formulary

BENEFIT	BENEFIT AMOUNT	ANNUAL LIMIT
Alternatives to Hospitalisation i. Step down facilities ii. Hospice (ward fees and disposables) iii. Home nursing	100% of Agreed Rate , or 100% of Cost in the case of PMBs	Subject to PMB regulations, Pre-authorisation and the application of Clinical and Funding Protocols.
Hospitalisation for psychiatric conditions/ substance abuse	100% of Cost	Limited to PMBs only and admission to a DSP facility. Subject to Pre-authorisation and the application of Clinical and Funding Protocols.
General Practitioner and Specialist procedures and consultations, including confinements in hospitals	100% of Agreed Rate	Subject to Overall Annual Limit.
Confinements Natural Birth Emergency Caesareans only	100% of Agreed Rate, unless a PMB, in which case 100% of cost	 Uncomplicated: Subject to a limited of R36 700 per confinement Complicated: Subject to a limit of R53 600 per confinement Subject to a limit of R53 600 per confinement. No benefits for elective caesareans.
Neonatal intensive care	100% of Agreed Rate	Limited to R77 100 **per annum**. PMB admissions are paid at 100% of cost and will accrue to this limit, but not be subject to the limit.
Blood transfusions and Technician services	100% of Agreed Rate	Subject to Overall Annual Limit.
Radiology and Pathology in-hospital	100% of Agreed Rate	Subject to Overall Annual Limit and the application of Clinical and Funding Protocols.
Specialised Radiology (MRI & CT scans), in and out-of-hospital	100% of Cost	Limited to PMBs only. Subject to Pre-authorisation and the application of Clinical and Funding Protocols.
Renal dialysis	100% of Cost	Limited to PMBs only and admission.
ER24 (Emergency Medical Services Only)	100% of Agreed Rate	Subject to Pre-authorisation
Internal prostheses	100% of Cost	Limited to PMB only.

BENEFIT	BENEFIT AMOUNT	ANNUAL LIMIT
		Subject to Pre-authorisation and the application of Clinical and Funding Protocols.
Maxillo-Facial Surgery (excluding Specialised Dentistry)	100% of Cost	Limited to PMBs only and admission to a DSP facility.
Organ Transplants (Hospitalisation and Surgery)	100% of Cost	Limited to PMBs only and admission to a DSP facility.
Oncology Treatment (including all in & out-of-hospital treatment and medication & materials)	100% of Cost	Limited to PMBs only and admission to a DSP facility. Subject to Pre-authorisation and registration on the Oncology Management Programme
HIV/AIDS	100% of Cost	Treatment within PMB protocols at DSP is unlimited. Subject to Managed Care Protocols and registration on the HIV/AIDS Management Programme
Outpatient surgical procedures (List of procedures below**)	100% of Agreed Rate	Subject to Overall Annual Limit
Speech therapy, Physiotherapy, Audiology, Occupational Therapy as part of a hospital event or resulting from a hospital event for a period of 6 weeks post discharge	100% of Agreed Rate	Subject to Pre-authorisation and the application of Clinical and Funding Protocols

**OUT-OF-HOSPITAL SURGICAL PROCEDURES LIST

The following procedures, if performed in a doctor's rooms are covered from the Overall Annual Limit, and are subject to Pre-authorisation and Managed Care Protocols. Anaesthetic costs, if applicable, are covered for local/regional anaesthetic and conscious sedation costs.

GASTRO-ENTEROLOGY

Gastroscopy and related procedures

Colonoscopy, Oesophagoscopy, Sigmoidoscopy and related procedures

R2 500 co-payment if these are performed in hospital without an approved clinical indication and Scheme approval.
Anaesthetic costs related to these scopes are limited to local or regional anaesthetic.
General anaesthetic costs are not covered

OPHTHALMOLOGY

Treatment of retina and choroids by cryotherapy

Pan-retineal photocoagulation in one sitting

Laser capsulotomy

Laser trabeculuplasty

Laser apparatus hire fee

Please note: Costs related to Lasik eye surgery are excluded from the benefits.

OTHER

Circumcision

EMERGENCY ROOM TREATMENT

Emergency Treatment in a trauma or casualty facility of a hospital, and all associated costs, where such treatment was either due to an emergency or resulted in an admission into hospital will be paid at 100% of the Agreed Tariff, unless a PMB in which case it will be paid at 100% of Cost.

Where such treatment has prevented an admission into hospital and / or where such treatment could not be rendered in a doctor's consultation room, the trauma fee and all associated costs will be paid from the In-hospital benefits at 100% of Agreed Tariff, unless a PMB in which case it will be paid at 100% of Cost, subject to the Overall Annual Limit.

HEALTH RISK ASSESSMENT

One Health Risk Assessment per beneficiary over the age of 21 years at a Network Pharmacy Clinic; or a digital Health Risk Assessment via the Multiply Mobile App.

TABLE 2: OUT-OF-HOSPITAL BENEFITS

OUT-OF-HOSPITAL PREVENTATIVE PROCEDURES	PAID FROM INSURED BENEFITS AT 100% OF SCHEME RATE
Flu vaccine injection	1 per beneficiary per year
Preventative Health Screenings, limited to: • Blood Pressure Measurements • Blood Glucose Screening (finger prick test) • Cholesterol Screening (finger prick test) • Body Mass Index	These screening tests are to be undertaken at any Pharmacy Network Providers, are subject to Scheme Protocols and limited to R362 per beneficiary per year.
Cholesterol tests	One of the following tariff codes will be allowed: • 4025 • 4026 • 4027 • 4028 • 4170
Pap Smears	. The following tariff code will be allowed: • 4566 • 4559
Prostate Specific Antigen (PSA) testing	The following tariff code will be allowed: • 4519
Colorectal cancer screening: Fecal occult blood test/Fecal Immunochemical test	50 years and older or family history •Fecal occult blood annually • 4351 • 4352
Mammogram	Beneficiary 40 years and older/clinically indicated. Once every 2 years

OUT-OF-HOSPITAL PREVENTATIVE PROCEDURES	PAID FROM INSURED BENEFITS AT 100% OF SCHEME RATE
	High risk members • 3605 • 34100 • 34101

OUT-OF-HOSPITAL MATERNITY BENEFITS	SUBJECT TO REGISTRATION ON THE PRIMARY OPTION MATERNITY PROGRAMME
GP consultations	Supervision of uncomplicated pregnancies at the Network GP up to week 12.
Specialist visits	Antenatal visits should thereafter be obtained from a Gynaecologist. Visits to a Gynaecologist are limited to 2 visits paid from the Insured benefit and thereafter subject to the out of hospital specialist limit. Pre-authorisation is required.
2D Ultrasounds	1 x 2D ultrasound scan in the first trimester.
Routine blood tests for abnormalities	Routine blood tests, upon request and referral by a Network GP, will be allowed subject to the Network Formulary
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TABLE 3: CHRONIC CONDITION BENEFITS INCLUDING PMB DIAGNOSIS AND TREATMENT PAIRS (DTPS) AND CHRONIC DISEASE LIST (CDL) CONDITIONS

CHRONIC CONDITIONS	BENEFIT AMOUNT	ANNUAL LIMIT
The Chronic Medicine Benefit is subject to the Network Chronic Medicine List, treatment protocols and Medicine Formulary. Registration on the Momentum Network Chronic Medicine Management Programme applies.	100% of SEP plus Agreed Dispensing Fee. (Subject to Chronic Medicine Reference Pricing and use of a Momentum Network Pharmacy)	The Scheme's PMB DTP & CDL programme offers benefits in accordance with approved Care Plans in respect of the diagnosis, treatment and care for such conditions. Medicine to be supplied by the Network as arranged with the beneficiary or provider. If medicines are voluntarily obtained from a provider

Limited to the Network GP as the prescriber.		other than the Scheme's DSP, a 30% co-payment could be applied.

26 CDL conditions:

Addison's disease, Asthma, Bipolar mood disorder, Bronchiectasis, Cardiac failure, Cardiomyopathy disease, Chronic renal failure, Coronary artery disease, Chronic obstructive pulmonary disorder, Crohn's disease, Dysrhythmias, Epilepsy, Glaucoma, Haemophilia, Hyperlipidaemia, Hypertension, Hypothyroidism, Multiple sclerosis, Parkinson's disease, Rheumatoid arthritis, Schizophrenia, Systemic lupus erythematosus, Ulcerative colitis, Antiretroviral therapy, Diabetes Insipidus, Diabetes Mellitus Type 1 & 2.

Additional Chronic Conditions:

Acne, Allergic Rhinitis, Depression, Migraine, Gout and Osteoarthritis.

TABLE 4: OUT OF HOSPITAL BENEFITS

The benefits described below are obtainable via the Momentum CareCross Network.

GENERAL PRACTITIONERS, SPECIALISTS AND PHYSIOTHERAPY OUT-OF-HOSPITAL	BENEFIT	ANNUAL LIMIT
General practitioners, consultations and visits	100% of Agreed Rate	Unlimited medically necessary visits at the Network GP. Includes the following minor trauma procedures, subject to Network protocols: Nebulisation, Circumcision, Removal of Foreign Body, Stitching of wound, ECG, Drainage of Abscess, Infusions, Limb Cast, Excision & Repair, Integumentary System
Emergency / out of network visits		3 visits per family per annum to a maximum of R1 200 per family per annum at any GP or casualty room. No benefit for outpatient facility fees unless as specified under table 1, Emergency Room Treatment
Specialists - including consultations, acute medicines, radiology and	100% of Agreed Rate	2 visits per family up to a maximum of R2 210 per

GENERAL PRACTITIONERS, SPECIALISTS AND PHYSIOTHERAPY OUT-OF-HOSPITAL	BENEFIT	ANNUAL LIMIT
pathology requested by the network specialist		annum at a Network Specialist. Subject to referral by a Network GP and Pre-authorisation
Physiotherapy services	100% of Agreed Rate	Combined limited with out-of-hospital Specialist benefit. Subject to Managed Care Protocols and Pre-authorisation.
Clinical psychology and psychiatric consultations	100% of Agreed Rate	Limited to PMB and only at DSP. Subject to Managed Care Protocols and Pre-authorisation

DENTISTRY	BENEFIT	ANNUAL LIMIT
Conservative Dentistry: Fillings, extractions, X-rays prophylaxis and pain relief (excludes root canal treatment)	100% of Agreed Rate	Subject to Network Dental Protocols.
Dentures	100% of Agreed Rate	Subject to Network Dental Protocols and specified benefits. Available only to beneficiaries over the age of 21. A 24-month benefit cycle applies.
Specialised Dentistry: Orthodontic, Periodontic, Crowns, Bridgework, Dental Implants and Osseo-Integration	No Benefit	No Benefit

MEDICATION	BENEFIT	ANNUAL LIMIT
Acute Medicines prescribed by medical practitioners Subject to the Medicine Reference Pricing	100% of Agreed Rate or SEP and Agreed Dispensing Fee Excludes administration fee	Subject to the Network Formulary Medicines are obtainable at point of service or via a prescription, from a scripting Network GP, at a Mediscor-enabled pharmacy.
Pharmacy Advised Therapy: excludes homeopathic and naturopathic medicines, contraceptives, nutritional supplements and vitamins	100% of Agreed Rate or SEP & Agreed Dispensing Fee. Excludes administration fee	R120 per script, limited to a maximum of R365 per family per annum.

OPTICAL	BENEFIT	ANNUAL LIMIT
Optometric tests	100% of Agreed Rate	1 eye test per beneficiary every 24 months Subject to the Network Protocols
Spectacles: lenses and frames	100% of Agreed Rate	1 pair of white standard mono or bifocal lenses in a standard frame up to the value of R244. **Or** contact lenses to the value of R635 in lieu of spectacles. Subject to the Network protocols and qualifying norms. No benefit for tinting, coatings etc.

RADIOLOGY AND PATHOLOGY	BENEFIT	ANNUAL LIMIT
Basic Radiology	100% of Scheme Rate	Subject to the Network list of X-rays and protocols.
Basic Pathology	100% of Agreed Rate	Subject to the Network list of blood tests and protocols
MRI and CT Scans (in & out of hospital)	100% of Cost	Limited to PMB only, subject to Managed Care Protocols and Pre-authorisation

EXTERNAL APPLIANCES	BENEFIT	ANNUAL LIMIT
Hearing aids, orthopaedic boots, surgical collars, wheelchairs, nebulisers and oxygen equipment, etc.	100% of cost	Subject to PMB only and limited to R6 660 per family. Subject to Pre-authorisation and the application of Clinical and Funding Protocols

ALTERNATIVE SERVICES	BENEFIT	ANNUAL LIMIT
Homeopaths, naturopaths and chiropractors, speech therapy, audiology, occupational therapy, podiatry etc.	No Benefit	No Benefit