ANNEXURE B.2 – BENEFIT OPTIONS
2024 PACE RANGE

2.1 GENERAL CONDITIONS OF THE BENEFIT OPTIONS

2.1.1 Members are entitled to the benefits indicated in this Annexure B of the registered Rules during a financial year, which shall run from 1 January to 31 December, and such benefits extend through the Member to his Dependant(s). A Member shall no later than 31 December prior to the year upon which it is intended that the change take place, elect in writing to participate in any one of the available options.

2.1.2 The Scheme's benefits on accounts properly lodged in terms of Rule 15 of the registered Rules shall be granted as shown in each paragraph and/or benefit options hereunder and the Member shall be liable for the difference between the Scheme's benefits and the full amount of the account.

2.1.3 No benefits shall be granted on accounts reaching the Scheme after the last day of the 4th (fourth) month following the date on which the service was rendered.

2.1.4 Granting of benefits shall be subject to, but not limited to, treatment protocols, funding guidelines, preferred providers, designated service providers (DSP), network option services, the Mediscor Reference Price (MRP) on all medicine where applicable and medicine formularies accepted by the Scheme. Benefits shall be subject to the exclusions referred to in Annexure C of the registered Rules.

2.1.5 Where a maximum amount of benefits has been imposed per financial year, the benefits shall be calculated at the maximum for the financial year in which the service was rendered. The maximum benefits for which a Member and/or his Dependant(s) qualify shall be determined in accordance with the actual membership status at the date on which the service is rendered.

2.1.6 A Member and/or his Dependant(s) shall be entitled to pro-rata benefits calculated from the date of enrolment up to the end of the financial year in which they join the Scheme, and shall include a benefit cycle, shown on the applicable benefit, which is effective from the date of service.

2.1.7 Where an account has been paid by the Member, such specified account plus proof of payment must be submitted to the Scheme before the last day of the 4th (fourth) month following the date on which the service was rendered. The Scheme will then refund the Member the applicable benefit amount.

2.1.8 Payment of accounts is restricted to the maximum amount of the benefit entitlement in terms of the applicable benefit and option elected. Benefits shall be paid as follows (whichever is applicable):

2.1.8.1 At 100% of Scheme tariff, which refers to the tariff approved annually by the Board of Trustees or the negotiated rate for hospitals and designated or preferred service providers.

2.1.8.2 Notwithstanding any provisions to the contrary in this Annexure, accounts in respect of the diagnosis, treatment and care of Prescribed Minimum Benefits (PMBs), as per the standard of care in the State sector, shall be payable at cost, without deductibles or the use of co-payments, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations: Provided that:

2.1.8.2.1 Payments shall first be from the specified limit(s) on the applicable benefit before continued funding in respect of PMB may be accessed; and

2.1.8.2.2 The funds in a Member's Medical Savings Account (i.e. PMSA and Vested Medical Savings Account) shall not be used to pay for the costs of a PMB.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4

2.2. HOSPITAL, HOSPITAL-RELATED BENEFITS AND OTHER MAJOR MEDICAL EXPENSES

- All hospital and hospital-related benefits shall be subject to Pre-authorisation, major medical expenses which require Pre-authorisation shall be indicated.
- Comprehensive benefits are offered for all pre-authorised services and authorised emergency services rendered during hospitalisation, i.e. from the day of admission up to and including the day of discharge.
- No benefits in a private hospital or day clinic shall be granted by the Scheme or its proxy if Pre-authorisation and an authorisation number have not been obtained:
  - In the event of planned major operations and dental procedures, Members are advised to obtain Pre-authorisation at least 2 (two) weeks in advance to ensure that the Member is aware of applicable benefits, limits, network restrictions, etc., before the event.
  - In an emergency, on the 1st (first) working day after admission to a hospital, or at the first reasonable opportunity as may be determined by the Scheme.
- Late authorisations will be subject to, but not limited to, clinical review, application of rules, benefits, protocols, funding guidelines, as well as the PMB status of the services rendered.
- If Pre-authorisation and an authorisation number have been obtained for treatment in a private hospital or day clinic but the treatment cost exceeds the authorised benefits, only the benefits of the authorised treatment cost shall be granted and the Member shall be liable for payment of the excess to the service provider, unless if the excess costs were as a direct result of treatment received and necessary for the beneficiary and authorisation could not be obtained in time.
- No benefits in respect of MRI scans and computer tomographic studies shall be granted if an authorisation number has not been obtained in advance or, in an emergency, on the 1st (first) working day after admission to a hospital, by the Scheme or its proxy.
- Full cross subsidisation between Members shall apply without an annual limit.
- The Scheme's list of contracted private hospitals, contracted State facilities and designated and preferred service providers, available on the Scheme's website or via the Contact Centre, shall be applicable to benefits.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.1 Hospitalisation: Pre-authorisation must be obtained for accommodation (hospital stay) in a general ward, intensive-care and high-care unit, theatre and material.	Benefits shall be at 100% of Scheme tariff/cost*.			
2.2.2 Take-home medicine: Medicine supplied by the hospital when a patient is discharged.	Medicine prescribed by the treating provider for a patient discharged from hospital, relating to the admission, to take home will be paid at 100% of Scheme tariff/cost* for a maximum supply of 7 (seven) days.			
2.2.3 Biological medicine during hospitalisation Biological medicine is a substance that is made from a living organism or its products and is used in the prevention, diagnosis, or treatment of acute and chronic diseases.	Benefits shall be at 100% of Scheme tariff/cost*, subject to pre-approval and limited to R33 296 per family per financial year.	Benefits shall be at 100% of Scheme tariff/cost*, subject to pre-approval and the biologicals and other high-cost medicine benefit limit indicated on Rule 2.3.3.		
2.2.4 Treatment in mental health clinics	Benefits shall be at 100% of Scheme tariff/cost*, subject to the length of stay limited to 21 (twenty-one) days per beneficiary per financial year and Pre-authorisation.			
2.2.5 Treatment of chemical and substance abuse	Benefits shall be at 100% of Scheme tariff/cost*, subject to the following: - Pre-authorisation; - DSPs;			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- The length of stay shall be limited to 21 (twenty-one) days for in-hospital or limited to R37 352 per beneficiary per financial year, whichever comes first. OR - 15 (fifteen) contact sessions for out-patient psychotherapy per condition, per beneficiary per financial year.			
2.2.6 Consultations and procedures: Consultations, visits, operations, surgical procedures and anaesthetics for surgical procedures during hospitalisation.	Claims submitted by General Practitioners (GPs) and specialists for treatment during hospitalisation shall be paid at 100% of Scheme tariff/cost*.			
2.2.7 Organ transplants (in and/or out of hospital): Pre-authorisation must be obtained.	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules, and shall be paid at cost as per PMB regulations.			
2.2.8 Stem cell transplants (in and/or out of hospital): Pre-authorisation must be obtained.	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules, and shall be paid at cost as per PMB regulations. The donor search and related costs shall be limited to the Scheme approved amount per financial year.			
2.2.9 Blood transfusion	Blood, operators' fees, transport charges and apparatus payable at 100% of Scheme tariff/cost*.			
2.2.10 Dental / Oral / Jaw surgery	- Pre-authorisation must be obtained for any surgical procedure that needs to be performed in a theatre and shall be payable at 100% of Scheme tariff.			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- The treatment of certain PMB conditions, as per the standard of care in the State sector shall be paid at cost, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations.			
2.2.10.1 Dental and oral surgery (in and/or out of hospital):	Benefits shall be at 100% of Scheme tariff limited to R9 338 per family per financial year for the following procedures performed either in or out of hospital: - Surgical extractions of teeth / roots / impactions / failed implants; - Surgical drainage of dental abscess; - Alveolectomy / alveolotomy (preparatory surgery for dental prosthesis); - Root canal related surgery;	Benefits shall be at 100% of Scheme tariff limited to R15 518 per family per financial year for the following procedures performed either in or out of hospital: - Surgical extractions of teeth / roots / impactions / failed implants; - Surgical drainage of dental abscess; - Alveolectomy / alveolotomy (preparatory surgery for dental prosthesis); - Root canal related surgery;	Benefits shall be at 100% of Scheme tariff limited to R19 500 per family per financial year for the following procedures performed either in or out of hospital: - Surgical extractions of teeth / roots / impactions / failed implants; - Surgical drainage of dental abscess; - Alveolectomy / alveolotomy (preparatory surgery for dental prosthesis); - Root canal related surgery;	Benefits shall be at 100% of Scheme tariff limited to R23 345 per family per financial year for the following procedures performed either in or out of hospital: - Surgical extractions of teeth / roots / impactions / failed implants; - Surgical drainage of dental abscess; - Alveolectomy / alveolotomy (preparatory surgery for dental prosthesis); - Root canal related surgery; - Dental implant related surgery;

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Dental implant related surgery; - Pre-prosthetic (preparatory to dental prosthetics) surgery; - Orthodontic related / orthognathic surgery.	- Dental implant related surgery; - Pre-prosthetic (preparatory to dental prosthetics) surgery; - Orthodontic related / orthognathic surgery.	- Dental implant related surgery; - Pre-prosthetic (preparatory to dental prosthetics) surgery; - Orthodontic related / orthognathic surgery.	- Pre-prosthetic (preparatory to dental prosthetics) surgery; - Orthodontic related / orthognathic surgery.
2.2.10.2 Major maxilla-facial surgery, strictly related to certain conditions	Benefits shall be at 100% of Scheme tariff limited to R15 105 per family per financial year, strictly for the following conditions: - Severe trauma (soft tissue injuries, fractures of jaws and facial bones); - Cleft lip and palate; - Crouson's disease; - Malunited craniomaxillary disjunction; - Post-traumatic defects (root residues in sinus,	Benefits shall be at 100% of Scheme tariff strictly for the following conditions: - Severe trauma (soft tissue injuries, fractures of jaws and facial bones); - Cleft lip and palate; - Crouson's disease; - Malunited craniomaxillary disjunction; - Post-traumatic defects (root residues in sinus, secondary oro-nasal fistula, faciostenosis); - Internal TM joint surgery (condylectomy, arthrocentesis, arthroplasty, total joint reconstruction); - Salivary gland surgery (removal of gland or salivary stone); - Life threatening sepsis (Ludwig's angina); and - Confirmed oral cancer.		

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	secondary oro-nasal fistula, faciostenosis); - Internal TM joint surgery (condylectomy, arthrocentesis, arthroplasty, total joint reconstruction); - Salivary gland surgery (removal of gland or salivary stone); - Life threatening sepsis (Ludwig's angina); and - Confirmed oral cancer.			
2.2.11 Prosthesis Benefits	Benefits shall subject to the following: - Pre-authorisation; - Preferred providers or DSPs; - The treatment of certain PMB conditions, as per the standard of care in the State sector shall be paid at cost, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations; and - Services for non-PMB conditions shall be based on Scheme tariff or contracted fee and shall be subject to exclusions for joint replacement surgery.			
2.2.11.1 Prosthesis – Internal	Benefits shall not be pro-rated and shall be paid at	Benefits shall not be pro-rated and shall be paid at	Benefits shall not be pro-rated and shall be paid at	Benefits shall not be pro-rated and shall be paid at 100% of

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
Prosthesis surgically implanted during operations for the replacement of parts of the human body for functional medical reasons, including delivery systems and related items.	100% of Scheme tariff/cost* limited to the over-all limit of R104 366 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R68 250; - Pacemaker dual chamber limited to R64 955; - Endovascular and catheter-based procedures and delivery mechanisms – no benefit; - Spinal prosthesis including artificial disk (single level based) shall be limited to R38 038;	100% of Scheme tariff/cost* limited to the over-all limit of R134 028 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R68 250; - Pacemaker dual chamber shall be limited to R72 438; - Spinal prosthesis including artificial disk (single level based) shall be limited to R67 193; - Drug-eluting stent shall be limited to R21 972; - Mesh shall be limited to R21 972;	100% of Scheme tariff/cost* limited to the over-all limit of R134 715 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R72 450; - Pacemaker dual chamber shall be limited to R72 438; - Spinal prosthesis including artificial disk (single level based) shall be limited to R67 321; - Drug-eluting stent shall be limited to R21 972; - Mesh shall be limited to R21 972;	Scheme tariff/cost* limited to the over-all limit of R155 450 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R72 450; - Pacemaker dual chamber shall be limited to R72 438; - Spinal prosthesis including artificial disk (single level based) shall be limited to R77 732; - Drug-eluting stent shall be limited to R25 886; - Mesh shall be limited to R22 796;

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Drug-eluting stent – no benefit apart from PMB conditions and DSP products only; - Mesh shall be limited to R14 282; - Gynaecological/Urological prosthesis shall be limited to R10 299; - Lens implant shall be limited to R7 828 a lens per eye; - Functional prosthesis – items used to replace or augment an impaired bodily function - shall be limited to R35 700.	- Gynaecological/Urological prosthesis shall be limited to R16 409; - Lens implant shall be limited to R14 090 a lens per eye; - Hip prosthesis and other major joints shall be limited to R60 353; - Knee prosthesis shall be limited to R70 035; - Other minor joints shall be limited to R26 022; and - Functional prosthesis – items used to replace or augment an impaired bodily function - shall be limited to R37 800.	- Gynaecological/Urological prosthesis shall be limited to R16 479; - Lens implant shall be limited to R14 090 a lens per eye; - Hip prosthesis and other major joints shall be limited to R60 422; - Knee prosthesis shall be limited to R70 378; - Other Minor joints shall be limited to R26 022; and - Functional prosthesis – items used to replace or augment an impaired bodily function - shall be limited to R37 800.	- Gynaecological/Urological prosthesis shall be limited to R18 814; - Lens implant shall be limited to R20 832 a lens per eye; - Hip prosthesis and other major joints shall be limited to R69 555; - Knee prosthesis shall be limited to R80 540; - Other Minor joints shall be limited to R25 886; and - Functional prosthesis – items used to replace or augment an impaired bodily function - shall be limited to R42 000.
2.2.11.2 Prosthesis – External: Prosthesis used after operations for the replacement of parts of the human body for functional medical	Benefits shall be at 100% of Scheme tariff limited to R26 504 per family per financial year:	Benefits shall be at 100% of Scheme tariff limited to R31 584 per family per financial year:	Benefits shall be at 100% of Scheme tariff limited to R31 723 per family per financial year:	Benefits shall be at 100% of Scheme tariff limited to R35 842 per family per financial year:

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
reasons, including delivery systems and related items. A list of prostheses covered by the Scheme can be requested from the Scheme.	- 2 (two) quotations may be required; - Preferred providers or DSPs; and - Artificial limbs are limited to 1 (one) limb every 60 (sixty) months, except for PMBs where requirements in terms of the amputated limbs will be assessed by the Scheme in line with what is considered predominant in the public hospital practice. - Repair work to artificial limbs will be funded from the Medical aids, apparatus and appliances benefit indicated in Rule 2.7.4.	- 2 (two) quotations may be required; - Preferred providers or DSPs; and - Artificial limbs are limited to 1 (one) limb every 60 (sixty) months, except for PMBs where requirements in terms of the amputated limbs will be assessed by the Scheme in line with what is considered predominant in the public hospital practice. - Repair work to artificial limbs will be funded from the Medical aids, apparatus and appliances benefit indicated in Rule 2.7.4.	- 2 (two) quotations may be required; - Preferred providers or DSPs; and - Artificial limbs are limited to 1 (one) limb every 60 (sixty) months, except for PMBs where requirements in terms of the amputated limbs will be assessed by the Scheme in line with what is considered predominant in the public hospital practice. - Repair work to artificial limbs will be funded from the Medical aids, apparatus and appliances benefit indicated in Rule 2.7.4.	- 2 (two) quotations may be required; - Preferred providers or DSPs; and - Artificial limbs are limited to 1 (one) limb every 60 (sixty) months, except for PMBs where requirements in terms of the amputated limbs will be assessed by the Scheme in line with what is considered predominant in the public hospital practice. - Repair work to artificial limbs will be funded from the Medical aids, apparatus and appliances benefit indicated in Rule 2.7.4.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.11.3 Exclusions on joint replacement surgery for non-PMB conditions	No benefit for joint replacement surgery, except for PMBs, subject to the following prosthesis limits, which form part of the Prosthesis – Internal over-all limit, at 100% contracted fees: - Hip prosthesis and other major joints shall be limited to R38 725; - Knee prosthesis shall be limited to R51 497; and - Other minor joints shall be limited to R15 999.	Not applicable		
2.2.12 Medically necessary breast reduction surgery Including fees for the surgeon and anaesthetist	No benefit			Benefits shall be at 100% of Scheme tariff limited to R55 493 per family per financial year, subject to Pre-authorisation and protocols.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.13 Orthopaedic and medical appliances during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost* for back, leg, arm and neck support, crutches, surgical footwear and elastic stockings provided before discharge from hospital.			
2.2.14 Pathology during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*.			
2.2.15 Basic radiology during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*.			
2.2.16 Specialised diagnostic imaging during hospitalisation	Benefits shall be at 100% of Scheme tariff for MRI scans, CT scans and isotope studies, subject to Pre-authorisation.			
2.2.17 Oncology benefits (in or out of hospital)	Oncology Programme. Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.			
2.2.18 Breast surgery for cancer	Treatment of the unaffected (non-cancerous) breast shall be limited to PMB provisions and is subject to Pre-authorisation and funding guidelines.			
2.2.19 Peritoneal dialysis and haemodialysis (in or out of hospital)	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.			
2.2.20 HIV/AIDS benefits (in or out of hospital)	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.			
2.2.21 Confinements	Benefits shall be at 100% of Scheme tariff/cost*, even if the baby dies before registration, for the following: - Medical practitioners;			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Nursing home and hospital fees in accordance with the provisions of the "Hospitalisation" benefit; - Midwife assisted births in an Active Hospital Birth Unit or home confinement by a midwife. Transport fees, hospital facility fees, renting of a birth pool, medical disposables or medication, antenatal consultations, doulas and breastfeeding support shall be excluded from benefits if these are not PMB level of care; and - Midwife assisted births at a private midwife birth house. Transport fees, renting of a birth pool, antenatal consultations, doulas and breastfeeding supports shall be excluded from benefits if these are not PMB level of care.			
2.2.22 Refractive surgery and other procedures done to improve or stabilise vision, except for cataracts	Benefits shall be at 100% of Scheme tariff limited to R10 381 per eye, subject to Pre-authorisation and protocols.	Benefits shall be at 100% of Scheme tariff limited to R10 848 per eye, subject to Pre-authorisation and protocols.	Benefits shall be at 100% of Scheme tariff limited to R11 673 per eye, subject to Pre-authorisation and protocols.	
2.2.23 Supplementary services during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*, provided that the services are related to the hospital admission of the patient and are in line with the Scheme funding guidelines and protocols, for supplementary services which include services rendered by physiotherapists, masseurs, chiropractors, osteopaths, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech therapists, biokinetics, stoma therapist and social workers.			
2.2.24 Alternatives to hospitalisation (i.e. procedures done in the doctor's rooms)	Benefits shall be at 100% of Scheme tariff subject to: - Pre-authorisation; - Step-down facilities approved by the Scheme; and - Services must be rendered by registered private nurses and hospices.			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.25 Advance illness benefit	Benefits shall be at 100% of Scheme tariff/cost* limited to R83 239 per beneficiary per financial year, subject to Pre-authorisation and treatment plan.	Benefits shall be at 100% of Scheme tariff/cost* limited to R133 182 per beneficiary per financial year, subject to Pre-authorisation and treatment plan.		
2.2.26 Ambulance and emergency evacuation services	Benefits shall be subject to: - Provision of benefits by Netcare 911, as the Scheme's capitated preferred provider for ambulance services. - Benefits shall only be payable if the evacuation service was involuntarily requested and delivered by a service provider other than the preferred provider: Provided that services in respect of PMB conditions shall be payable at cost, without deductibles or the use of co-payments, subject to the provisions of Rule 15.10 of the main rules read in conjunction with Annexure D.1 of these Rules, as shall be evaluated by the Scheme.			
2.2.27 International emergency medical cover	In addition to the provisions for foreign claims referred to in Rule 16.12 of the registered Bestmed Rules, the Member and his Dependant(s) qualify for additional benefits which shall be at 100% contracted tariff subject to the following: - Provision of benefits by Europ Assistance SA, as the Scheme's capitated preferred provider for international travel insurance. - Cover for leisure and business travel for emergency medical and related expenses: ▪ Leisure travel is limited to 45 (forty-five) days and R500 000 cover for travelling to the United States of America (USA) for a family i.e. Member and Dependant(s). All other countries are covered up to 90 (ninety) days for R3 million for a family i.e. Member and Dependant(s).			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	▪ Business travel is limited to 45 (forty-five) days and R500 000 cover for travelling to the USA for a family i.e. Member and Dependant(s). All other countries are covered up to 45 (forty-five) days for R3 million for a family i.e. Member and Dependant(s). - A Member must give at least 48 (forty-eight) hours in advance when he and/or his Dependant(s) are traveling overseas. Failure to do so will result in claims being rejected. - General exclusions to services apply. Elective planned procedures undergone outside of South Africa are not covered.			
2.2.28 Day procedures at a day hospital facility	Day procedures at a day hospital or day clinic facility shall be funded at 100% of Scheme tariff/cost*, subject to: - Pre-authorisation; - Protocols and funding guidelines; and - DSPs and preferred providers A co-payment of R2 625 shall be incurred per event if a day procedure is voluntarily done by a non-DSP provider, or if the procedure is done in an acute hospital that is not a day hospital. If the provider is a DSP and does not work in a day hospital, the procedure shall be paid in full if it is done in an acute hospital, as per arrangement with the Scheme.			
2.3. MEDICINE BENEFITS Benefits for chronic, high-cost medicine, acute and over-the-counter (OTC) medicine shall be subject to: - Prior application and approval by the Scheme where indicated.				

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
- The Scheme treatment protocols and clinical funding guidelines. Motivations and reports by appropriate medical practitioners may be requested by the Scheme. - The Scheme's formulary (medicine list), where applicable. - Where medicines have generic alternatives registered with the South African Health Products Regulatory Authority (SAHPRA), the Scheme will reimburse those medicines up to the MRP for that active ingredient. - Benefit amount for medicine will be calculated at Single Exit Price (SEP), plus the dispensing fee as negotiated by the Scheme, plus VAT. - DSPs may apply. - Each prescription or repeat prescription shall be limited to one month's supply per beneficiary. The Scheme may, at its sole discretion and according to the relevant protocols, grant an advance supply of medicine upon receipt of the relevant application. - Non-CDL medicine benefits will apply for the conditions indicated with double asterisks (**) where provision is not made in the Diagnosis and Treatment Pairs constituting the PMB package as listed in the Medical Schemes Act. - Approved PMB, CDL and non-CDL chronic medicine costs shall be paid from the non-CDL limit first. Thereafter, only approved PMB and CDL chronic medicine costs shall be paid by the Scheme. Approved treatment for organ transplant, chronic renal failure, multiple sclerosis and haemophilia will be paid directly from Scheme risk and not non-CDL limit. - Approved PMB biological and non-PMB biological medicine costs shall be paid from the applicable biological medicine limit first. Thereafter, only approved PMB biological medicine costs shall be paid by the Scheme.				
2.3.1 Chronic medicine not listed on the chronic disease list ("non-CDL medicine")	Medicine on the formulary shall be covered at 90% of Scheme tariff with a 10% co-payment and non-formulary medicine shall be covered at	Medicine on the formulary shall be covered at 90% of Scheme tariff with a 10% co-payment and non-formulary medicine shall be covered at	Medicine on the formulary shall be covered at 90% of Scheme tariff with a 10% co-payment and non-formulary medicine shall be covered at	Medicine on the formulary shall be covered at 100% of Scheme tariff and non-formulary medicine shall be covered at 90% of Scheme tariff with a 10% co-payment.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	75% of Scheme tariff with a 25% co-payment. Payment shall be at Scheme tariff limited to M = R7 690 and M1+ = R15 380 for the following 7 (seven) non-CDL conditions: - Acne - Allergic rhinitis - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Eczema - Gout Prophylaxis** - Major Depression** shall be covered as a life-sustaining condition	80% of Scheme tariff with a 20% co-payment. Payment shall be at Scheme tariff limited to M = R10 500 and M1+ = R21 000 for the following 20 (twenty) non-CDL conditions: - Acne - Allergic rhinitis - Ankylosing Spondylitis - Alzheimer's disease - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Autism - Collagen diseases - Dermatomyositis	85% of Scheme tariff with a 15% co-payment. Payment shall be at Scheme tariff limited to M = R16 136 and M1+ = R32 272 for the following 20 (twenty) non-CDL conditions: - Acne - Allergic rhinitis - Ankylosing Spondylitis - Alzheimer's disease - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Autism - Collagen diseases - Dermatomyositis	Payment shall be at Scheme tariff limited to M = R23 000 and M1+ = R46 209 for the following 29 (twenty-nine) non-CDL conditions: - Acne - Allergic rhinitis - Ankylosing Spondylitis - Alzheimer's disease - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Autism - Blepharospasm - Collagen diseases - Dermatomyositis - Dystonia** - for ongoing or long-term chronic use

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	once the non-CDL benefit limit has been depleted - Migraine prophylaxis Subject to: - Prior application and approval by the Scheme and benefits shall be from the date on which the application was received by the Scheme or its proxy.	- Eczema - Gastro Oesophageal Reflux Disease (GORD)** - Gout Prophylaxis** - Major Depression** shall be covered as a life-sustaining condition once the non-CDL benefit limit has been depleted - Migraine prophylaxis - Neuropathy - Obsessive Compulsive Disorder - Osteoarthritis - Osteoporosis** - Paget's disease - Psoriasis - Urinary incontinence Subject to:	- Eczema - Gastro Oesophageal Reflux Disease (GORD)** - Gout Prophylaxis** - Major Depression** shall be covered as a life-sustaining condition once the non-CDL benefit limit has been depleted - Migraine prophylaxis - Neuropathy - Obsessive Compulsive Disorder - Osteoarthritis - Osteoporosis** - Paget's disease - Psoriasis - Urinary incontinence Subject to:	- Eczema - Gastro Oesophageal Reflux Disease (GORD)** - Gout Prophylaxis** - Hypopituitarism - Major Depression** shall be covered as a life-sustaining condition once the non-CDL benefit limit has been depleted - Migraine prophylaxis - Motor neuron disease - Neuropathy - Obsessive Compulsive Disorder - Osteoarthritis - Osteoporosis** - Paget's disease - Polyarthritis nodosa - Psoriasis - Psoriatic arthritis - Scleroderma

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
		- Prior application and approval by the Scheme and benefits shall be from the date on which the application was received by the Scheme or its proxy.	- Prior application and approval by the Scheme and benefits shall be from the date on which the application was received by the Scheme or its proxy.	- Sjogren's disease - Trigeminal neuralgia - Urinary incontinence Subject to: - Prior application and approval by the Scheme and benefits shall be from the date on which the application was received by the Scheme or its proxy.
2.3.2 Medicine for PMB conditions including the conditions listed on the chronic disease list (CDL)	Medicine on the formulary shall be covered at 100% Scheme tariff/cost* with no co-payment and voluntary use of non-formulary medicine shall be covered at 75% of Scheme tariff with a 25% co-payment.	Medicine on the formulary shall be covered at 100% Scheme tariff/cost* with no co-payment and voluntary use of non-formulary medicine shall be covered at 80% of Scheme tariff with a 20% co-payment.	Medicine on the formulary shall be covered at 100% Scheme tariff/cost* with no co-payment and voluntary use of non-formulary medicine shall be covered at 85% of Scheme tariff with a 15% co-payment.	Medicine on the formulary shall be covered at 100% Scheme tariff/cost* with no co-payment and voluntary use of non-formulary medicine shall be covered at 90% of Scheme tariff with a 10% co-payment. Subject to:

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	Subject to: Prior application and approval by the Scheme.	Subject to: Prior application and approval by the Scheme.	Subject to: Prior application and approval by the Scheme.	Prior application and approval by the Scheme.
2.3.3 Biological medicine: Biological medicine is a substance that is made from a living organism or its products and is used in the prevention, diagnosis, or treatment of acute and chronic diseases.	Scheme pre-approval is required and out-of-hospital benefits are limited to the treatment of certain PMB conditions, as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations, shall be paid at cost.	Subject to pre-approval, the benefits shall be paid at 100% of Scheme tariff/cost* with a maximum of R192 126 per beneficiary per financial year.	Subject to pre-approval, the benefits shall be paid at 100% of Scheme tariff/cost* with a maximum of R384 507 per beneficiary per financial year.	Subject to pre-approval, the benefits shall be paid at 100% of Scheme tariff/cost* with a maximum of R569 070 per beneficiary per financial year.
2.3.4 Other high-cost medicine	Benefits shall be at 100% of Scheme tariff/cost* and subject to pre-approval.			
2.3.5 Acute medicine	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be subject to	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be subject to	Benefits shall be subject to the overall day-to-day limit and the following maxima per financial year:

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	subject to the overall day-to-day limit and the following maxima per financial year: M = R2 721 and M1+ = R5 631 Benefits shall be for: - Medicine prescribed out of a hospital by a medical practitioner, a contracted Pharmacist Primary Care Drug Therapy (PCDT) pharmacist, dentist or a person authorised thereto by law. - Homeopathic remedies, injections and herbal remedies with nappi code(s). - Benefits for homeopathic remedies, injections and	the overall day-to-day limit and the following maxima per financial year: M = R3 150 and M1+ = R6 300 Benefits shall be for: - Medicine prescribed out of a hospital by a medical practitioner, a contracted Pharmacist Primary Care Drug Therapy (PCDT) pharmacist, dentist or a person authorised thereto by law. - Homeopathic remedies, injections and herbal remedies with nappi code(s). - Benefits for homeopathic remedies, injections and	the overall day-to-day limit and the following maxima per financial year: M = R2 100 and M1+ = R4 725 Benefits shall be for: - Medicine prescribed out of a hospital by a medical practitioner, a contracted Pharmacist Primary Care Drug Therapy (PCDT) pharmacist, dentist or a person authorised thereto by law at 100% Scheme tariff. - Homeopathic remedies, injections and herbal remedies with nappi code(s) at 100% Scheme tariff.	M = R9 809 and M1+ = R15 237 Benefits shall be for: - Medicine prescribed out of a hospital by a medical practitioner, a contracted Pharmacist Primary Care Drug Therapy (PCDT) pharmacist, dentist or a person authorised thereto by law at 90% Scheme tariff with a 10% co-payment. - Homeopathic remedies, injections and herbal remedies with nappi code(s) at 90% Scheme tariff with a 10% co-payment.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	herbal remedies without nappi code(s) shall be paid from the Vested Medical Savings Account.	herbal remedies without nappi code(s) shall be paid from the Vested Medical Savings Account.	- Benefits for homeopathic remedies, injections and herbal remedies without nappi code(s) shall be paid from the Vested Medical Savings Account.	
2.3.6 Over-the-counter (OTC) medicine The member may choose how to access OTC medicine benefits: 1. The OTC medicine benefit with a set limit on the PMSA. OR 2. The OTC medicine benefit without a set limit on the PMSA to accumulate a self-payment gap.	1. The OTC medicine benefit up to the limit of R1 110 per family per financial year, paid at 100% of Scheme tariff from the PMSA. Benefit includes, but not limited to, purchases of sunscreen, vitamins and minerals with nappi codes on the Scheme's formulary. 1.1 Once the set limit has been reached, the member may access further OTC medicine benefits through the Vested Medical Savings Account where purchases shall be paid at 100% Scheme tariff. OR 2. OTC medicine benefit without a limit on the PMSA to accumulate a self-payment gap once the limit of R1 110 has been reached. 2.1 The threshold will be determined by the amount allocated to the annual PMSA at the beginning of the year, or pro-rated if the Member joins after January, from which OTC			100% of the Scheme tariff, subject only to funds being available in the PMSA. Benefit includes, but not limited to, purchases of sunscreen, vitamins and minerals with nappi codes on the Scheme's formulary.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	medicine purchases, in excess of the aforementioned set limit, will accumulate to a self-payment gap. 2.2 Once a self-payment gap has accumulated, the day-to-day health care services, as indicated in Rule 2.6 of this Annexure, will contribute towards the payment of the self-payment gap, thus reducing and ultimately closing the self-payment gap. The Member will only be able to access the Scheme's day-to-day benefits after contributing to the full amount of the self-payment gap. 2.3 The cost or Scheme tariff for services, whichever is lower, shall be used in the calculation of the contribution towards the self-payment gap: Non-contributing services or items shall not be taken into account in this calculation. 2.4 Where the annual PMSA is depleted, the Member will be liable for day-to-day claims (i.e. pay out of his own pocket) until he fully contributes to the self-payment gap amount. 2.5 The Member must continue to submit claims to the Scheme, even when the Member is in the self-payment gap, as this will inform the Scheme when the Member has fully contributed to the self-payment gap and consequently qualifies for the Scheme's day-to-day benefits. The claims must be submitted to the Scheme not later than the last day of the 4th (fourth) month following the month in which the relevant health service was rendered.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.4. PREVENTATIVE CARE AND WELLNESS BENEFITS	Benefits shall be at 100% of Scheme tariff and DSPs or preferred providers.			
2.4.1 Influenza vaccine	1 (one) vaccine per beneficiary per financial year.			
2.4.2 Pneumonia programme	Children under 2 (two) years of age: - As per the schedule of the Department of Health. Adult group: - Twice in a lifetime, with a booster if beneficiary is above 65 (sixty-five) years of age. - The Scheme in accordance with its protocol, will identify certain high-risk individuals who will be advised to be immunised.			
2.4.3 Travel vaccinations	Bestmed provides cover for certain mandatory travel vaccines for typhoid, yellow fever, tetanus, meningitis, hepatitis and cholera from Scheme risk benefits.			
2.4.4 Baby growth and development assessments	Children from 0 (zero) up to 2 (two) years of age: - 3 (three) assessments per year. - Assessments must be conducted at a Tempo partner pharmacy clinic.			
2.4.5 Paediatric immunisations	Paediatric vaccines according to the State recommended programme for babies and children.			
2.4.6 Female contraceptives	Applicable to all females of childbearing age: - Quantity and frequency depending on product up to the maximum of R2 678 per beneficiary per financial year, which includes all items classified in category of female contraceptives. - Intrauterine device (IUD) – insertion (consultation and procedure) of the device if done by a gynaecologist or GP once every 5 (five) years.			
2.4.7 Preventative dentistry	Benefits are applicable per beneficiary: **1. General full mouth examination by a general dentist (incl. gloves and use of sterile equipment for this visit):**			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- For beneficiaries under 12 (twelve) years - twice per financial year. - For beneficiaries 12 (twelve) years and older - once per financial year. **2. Full mouth intra-oral radiographs:** All ages, once every 36 (thirty-six) months. **3. Intra-oral radiograph:** All ages, 2 (two) x photos per financial year. **4. Scaling and/or polishing:** All ages, every 6 (six) months from the date of service. **5. Fluoride treatment:** All ages, every 6 (six) months from the date of service. **6. Fissure sealing:** Beneficiaries up to and including 21 (twenty-one) years, the frequency will be in accordance with accepted protocol. **7. Space maintainers:** During primary and mixed denture stage, once per space.			
2.4.8 Mammogram	Females 40 (forty) years and older - once every 24 (twenty-four) months.			
2.4.9 Human Papilloma Virus (HPV) vaccinations	Females 9 (nine) – 26 (twenty-six) years of age: - 3 (three) vaccinations per beneficiary. - Cervarix/Gardasil shall be funded at Mediscor Reference Price (MRP).			
2.4.10 Bone densitometry	No benefit	Once every 24 (twenty-four) months for all beneficiaries 45 (forty-five) years and older.		
2.4.11 Prostate Specific Antigen (PSA) test: Tariff codes claimed by	Males 50 (fifty) years and older: - Once every 24 (twenty-four) months per beneficiary. - To be done at urologist or GP. Urologist or GP consultation paid from the available consultation benefit.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
pathologists or nappi codes claimed by pharmacies in respect of this benefit are included.				
2.4.12 PAP smear: Tariff codes claimed by pathologists or nappi codes claimed by pharmacies in respect of this benefit are included.	Preventative benefit is subject to: - Females 18 (eighteen) years and older. - Once every 24 (twenty-four) months per beneficiary for PAP smear tariff code 4566 or 4559. - To be done at a gynaecologist or GP. - Consultation fee paid from the Preventative Care benefit.			
2.4.13 Glaucoma screening	No benefit	Preventative benefit is subject to: - Beneficiaries 50 (fifty) years and older. - Once every 12 (twelve) months per beneficiary. - To be performed by preferred optical network optometrists.		
2.4.14 Tempo programme: Benefits on the Tempo programme can only be accessed when a beneficiary undergoes a health risk assessment.	**1. Health risk assessments** Beneficiaries 16 (sixteen) years and older - 1 (one) per beneficiary per financial year. - This includes a biometric screening and lifestyle questionnaire that must be completed at Network pharmacy clinics, or onsite at selected Employer groups, or at an accredited Tempo biokineticist, or a Tempo GP, or a private Tempo nurse. Only participating Employer groups which allow onsite screening and nurses onsite, or allow the Scheme to conduct the assessment at the workplace. Alternatively, Members can obtain the services from their pharmacy clinics or accredited Tempo biokineticists or nurses. - Beneficiaries must complete a health risk assessment in order to unlock the biokineticist and dietician consultations that form part of the Tempo programme benefits.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	2. Fitness and nutritional interventions available to beneficiaries 16 (sixteen) years and older Fitness - 1 (one) fitness test at a Tempo biokineticist conducted in person; and - 1 (one) follow-up in person or virtual consultation at a Tempo biokineticist to obtain a personalised fitness/exercise plan. - Online fitness journeys and interventions are available to beneficiaries via their smartphones or the Bestmed website. Nutrition - 1 (one) nutritional assessment at a Tempo dietician; and - 1 (one) follow-up in person or virtual consultation at a Tempo dietician to obtain a personalised diet plan. - Online nutritional journeys and interventions are available to beneficiaries via their smartphones or the Bestmed website. **3. Emotional wellbeing journey** - The emotional wellbeing journey is offered online via smartphones and the Bestmed website. - The journey consists of 2 (two) self-assessments to be completed by beneficiaries 21 (twenty-one) years and older to determine the level of symptoms they may have in terms of depression and/or anxiety. The results sent by email to the beneficiaries will include a contact number that is available for 24 (twenty-four) hours and 7 (seven) days should the beneficiaries need more personalised assistance. - The rest of the journey consist of skills development exercises and challenges to empower beneficiaries to develop the necessary tools to cope with life's changes.			
2.5 MATERNITY BENEFITS	Benefits shall be at 100% of Scheme tariff per beneficiary per financial year, subject to the following:			

<table>
<tr><th>HEALTHCARE SERVICES</th><th>PACE1</th><th>PACE2</th><th>PACE3</th><th>PACE4</th></tr>
<tr><td></td><td colspan="4">Consultations:
- 9 (nine) antenatal consultations at either a GP/gynaecologist/midwife.
- 1 (one) post-natal consultation at either a GP/gynaecologist/midwife.

Ultrasounds:
- 1 (one) 2D ultrasound scan at 1st (first) trimester (between 10 (ten) to 12 (twelve) weeks) at a gynaecologist/GP/radiologist.
- 1 (one) 2D ultrasound scan at 2nd (second) trimester (between 20 (twenty) to 24 (twenty-four) weeks) at a gynaecologist/GP/radiologist.

Any item categorised as a maternity supplement can be claimed up to a maximum of R133 per claim, once a month, for a maximum of 9 (nine) months.</td></tr>
<tr><td rowspan="2">2.6 OPTOMETRY BENEFITS</td><td colspan="4">Optometry benefits are available per beneficiary every 24 (twenty-four) months from the date of service.
Services rendered by preferred optical network optometrists shall be payable at 100% of contracted fee. Services rendered by a non-network provider shall be paid at 100% Scheme tariff subject to the maxima indicated. The maximum amount indicated for contact lenses shall be applicable, irrespective if the beneficiary obtained services from a PPN network optometrist or a non–network provider.</td></tr>
<tr><td>Benefits from a preferred optical network optometrist shall be as follows:</td><td>Benefits from a preferred optical network optometrist shall be as follows:
- Consultations: 1 (one) per beneficiary at 100% of cost</td><td colspan="2">Benefits from a preferred optical network optometrist shall be as follows:
- Consultations: 1 (one) per beneficiary at 100% of cost</td></tr>
</table>

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Consultations: 1 (one) per beneficiary at 100% of cost - Spectacle frames or lens enhancements limited to R1 000 (Member frame refund value after network discount R750) AND - Lenses: standard lenses (i.e. single vision or bifocal or multifocal lenses) at 100% of cost OR - Contact lenses limited to R1 840 Benefits from a non-network provider shall be as follows: - Consultations: 1 (one) per beneficiary limited to R365	- Spectacle frames or lens enhancements limited to R1 040 (Member frame refund value after network discount R780) AND - Lenses: standard lenses (i.e. single vision or bifocal or multifocal lenses) at 100% of cost as well as lens enhancements limited to R750 OR - Contact lenses limited to R2 010 Benefits from a non-network provider shall be as follows: - Consultations: 1 (one) per beneficiary limited to R365 - Spectacle frames or lens enhancements limited to R780 AND - Lenses additional lens enhancements of R562.50: Single-vision lenses at R215 OR Bifocal lenses at R460 OR Multifocal lenses at R982.50 - In lieu of glasses Members can opt for contact lenses at R2 010		- Spectacle frames or lens enhancements limited to R1 040 (Member frame refund value after network discount R780) AND - Lenses: standard lenses (i.e. single vision or bifocal or multifocal lenses) at 100% of cost as well as lens enhancements limited to R750 OR - Contact lenses limited to R2 375 Benefits from a non-network provider shall be as follows: - Consultations: 1 (one) per beneficiary limited to R365

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Spectacle frames or lens enhancements limited to R750 AND - Lenses: Single-vision lenses at R215 OR Bifocal lenses at R460 OR Multifocal lenses at R982.50 - In lieu of glasses Members can opt for contact lenses at R1 840			- Spectacle frames or lens enhancements limited to R780 AND - Lenses additional lens enhancements of R562.50: Single-vision lenses at R215 OR Bifocal lenses at R460 OR Multifocal lenses at R982.50 - In lieu of glasses Members can opt for contact lenses at R2 375
2.7 OUT-OF-HOSPITAL BENEFITS	- Refer to Annexure B.4 for the conditions of payment from the Personal Medical Savings Account (PMSA) and the Vested Medical Savings Account. - Full cross subsidisation between Members shall apply without an annual limit, except in relation to the PMSA. - Day-to-day benefits may be subject to payment from the PMSA first and shall be indicated as such. - Benefits may be subject to the annual maxima for the Member with his Dependant(s) and/or as provided for on the benefit.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Benefits shall be paid at 100% of Scheme tariff/cost* as per the standard of care in the State sector.			
	The following combined overall limit for day-to-day benefits shall apply per financial year: M = R12 607 and M1+= R25 213	The following combined overall limit for day-to-day benefits shall apply per financial year: M = R15 750 and M1+= R31 500	The following combined overall limit for day-to-day benefits shall apply per financial year: M = R21 047 and M1+= R43 496	The following combined overall limit for day-to-day benefits shall apply per financial year: M = R41 472 and M1+= R66 878
2.7.1 GP, nurse and specialist consultations Consultations, visits, diagnostic examinations, injections and emergency unit visits (where a procedure room was used) with General Practitioners, contracted Nursing Clinical Services, contracted Pharmacist Primary Care Drug Therapy (PCDT) pharmacists, Specialists, Homeopaths and Herbalists.	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R2 596 and M1+ = R5 219	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R4 808 and M1+ = R9 744	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R5 082 and M1+ = R10 299	Benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R6 523 and M1+ = R10 575

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.7.2 Continuous/Flash Glucose Monitoring (CGM/FGM) benefit for Diabetics	Subject to the Medical Aids, apparatus and appliance benefit		Continuous/Flash Glucose Monitoring (CGM/FGM) at 100% of Scheme tariff limited to R22 197 per family per financial year, subject to Pre-authorisation.	Continuous/Flash Glucose Monitoring (CGM/FGM) at 100% of Scheme tariff limited to R27 746 per family per financial year, subject to Pre-authorisation.
2.7.3 Basic and specialised dentistry Includes basic and specialised dentistry not defined under Preventative dentistry benefits or Dental / Oral / Jaw surgical benefits.	Basic and specialised dentistry benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R4 778 and M1+ = R9 696 Specialised dentistry benefits include:	Basic and specialised dentistry benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R8 009 and M1+ = R16 019 Specialised dentistry benefits include:	Basic and specialised dentistry benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R8 630 and M1+ = R16 089 Specialised dentistry benefits include:	Basic and specialised dentistry benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R14 403 and M1+ = R24 310 Specialised dentistry benefits include: - Prosthodontics services (crowns, bridges, inlays, veneers and dentures);

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Prosthodontics services (crowns, bridges, inlays, veneers and dentures); - Periodontics services (gum diseases); - Orthodontic services (correction of irregular teeth by means of braces, retainers or similar treatment) are subject to Pre-authorisation; and - Dental implants, implant costs and all laboratory costs related to the aforementioned services.	- Prosthodontics services (crowns, bridges, inlays, veneers and dentures); - Periodontics services (gum diseases); - Orthodontic services (correction of irregular teeth by means of braces, retainers or similar) for beneficiaries over the age of 18 (eighteen) years are subject to Pre-authorisation; and - Dental implants, implant costs and all laboratory costs related to the aforementioned services.	- Prosthodontics services (crowns, bridges, inlays, veneers and dentures); - Periodontics services (gum diseases); - Orthodontic services (correction of irregular teeth by means of braces, retainers or similar) for beneficiaries over the age of 18 (eighteen) years are subject to Pre-authorisation; and - Dental implants, implant costs and all laboratory costs related to the aforementioned services.	- Periodontics services (gum diseases); - Orthodontic services (correction of irregular teeth by means of braces, retainers or similar) for beneficiaries over the age of 18 (eighteen) years are subject to Pre-authorisation; and - Dental implants, implant costs and all laboratory costs related to the aforementioned services.
		Orthodontic services (correction of irregular teeth by means of braces, retainers, or similar treatment) for beneficiaries	Orthodontic services (correction of irregular teeth by means of braces, retainers, or similar treatment) for beneficiaries	Orthodontic services (correction of irregular teeth by means of braces, retainers, or similar treatment) for

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
		up to 18 (eighteen) years of age. Pre-authorisation is required and benefits shall be at 100% of Scheme tariff. Claims shall be paid from the PMSA first. Once the funds in the PMSA have been depleted, benefits shall be limited to R7 769 per event per financial year, subject to the overall day-to-day limit.	up to 18 (eighteen) years of age. Pre-authorisation is required and benefits shall be at 100% of Scheme tariff. Claims shall be paid from the PMSA first. Once the funds in the PMSA have been depleted, benefits shall be limited to R9 989 per event per financial year, subject to the overall day-to-day limit.	beneficiaries up to 18 (eighteen) years of age. Pre-authorisation is required and benefits shall be at 100% of Scheme tariff limited to R12 208 per event per financial year, subject to the overall day-to-day limit.
2.7.4 Medical aids, apparatus and appliances, including wheelchairs and hearing aids Pre-authorisation must be obtained for all hearing aid devices fitted and the following documentation is required:	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R13 321 per family per financial year for appliances	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R12 084 per family per financial year for appliances that shall include any of the items listed below: - Back, leg, arm and neck support; - Surgical footwear; - Crutches;		Benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R12 084 per family per financial year for appliances that shall include any of the items listed below:

<table>
<tr><th>HEALTHCARE SERVICES</th><th>PACE1</th><th>PACE2</th><th>PACE3</th><th>PACE4</th></tr>
<tr><td rowspan="3">- A fully detailed audiogram;
- A comprehensive quotation, which includes, inter alia, the product name, clinical details (i.e. behind the ear, in the ear, custom) and the number of devices to be fitted;
- NAPPI code(s);
- Motivation for obtaining a hearing aid device; and
- In the case of providers who are not contracted with the Scheme, the product serial number(s) of the hearing aid device(s).</td><td>that shall include any of the items listed below:

- Back, leg, arm and neck support;
- Wheelchairs;
- Surgical footwear;
- Crutches;
- Elastic stockings;
- Repair work on artificial limbs, wheelchairs, etc.; and
- Stoma products, Oxygen and Diabetic supplies for non-PMB conditions.</td><td colspan="2">- Elastic stockings;
- Repair work on artificial limbs, wheelchairs, etc.;
- Stoma products, and
- Oxygen and Diabetic supplies for non-PMB conditions.</td><td>- Back, leg, arm and neck support;
- Surgical footwear;
- Crutches;
- Elastic stockings;
- Repair work on artificial limbs, wheelchairs, etc.;
- Stoma products,
- Oxygen supplies and Diabetic supplies for non-PMB conditions; and
- Insulin pump consumables.</td></tr>
<tr><td colspan="3">Wheelchairs at 100% of Scheme tariff limited to R16 342 per family every 48 (forty-eight) months.</td></tr>
<tr><td>Hearing aids and/or repair at 100% of Scheme tariff limited to R9 252 per family once every 24 (twenty-four) months.

Pre-authorisation is required together with the</td><td>Hearing aids and/or repair at 100% of Scheme tariff limited to R33 302 per beneficiary every 24 (twenty-four) months.

Pre-authorisation is required together with the</td><td>Hearing aids and/or repair at 100% of Scheme tariff limited to R37 490 per beneficiary every 24 (twenty-four) months.

Pre-authorisation is required together with the</td><td>Hearing aids and/or repair at 100% of Scheme tariff limited to R41 746 per beneficiary every 24 (twenty-four) months.

Pre-authorisation is required together with the documentation indicated on</td></tr>
</table>

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	documentation indicated on the Healthcare Services on this Rule 2.7.4.	documentation indicated on the Healthcare Services on this Rule 2.7.4.	documentation indicated on the Healthcare Services on this Rule 2.7.4.	the Healthcare Services on this Rule 2.7.4. Insulin pump, excluding consumables, at 100% of Scheme tariff limited to R48 572 per beneficiary every 24 (twenty-four) months. Pre-authorisation is required.
2.7.5 Supplementary services Benefits includes services rendered by physiotherapists, masseurs, chiropractors, osteopaths, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech therapists, biokinetics, private nursing (stoma therapy nursing, obtaining of specimen, observations and administration of medication, immunisations and IV's),	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R5 095 and M1+ = R10 575	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R3 675 and M1+ = R7 350	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R3 104 and M1+ = R6 523	Benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R6 523 and M1+ = R12 839

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
psychiatric treatment, psychologists and social workers.				
2.7.6 Wound care benefit Includes dressings and negative pressure wound therapy (NPWT) treatment and nursing services out of hospital.	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R4 188 per family per financial year.	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R7 535 per family per financial year.	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R10 500 per family per financial year.	Benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R15 930 per family per financial year.
2.7.7 Basic radiology and pathology	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R3 776 and M1+ = R7 554		Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year:	Benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R6 523 and M1+ = R12 839

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
			M = R4 120 and M1+ = R8 170	
2.7.8 Specialised diagnostic imaging MRI scans, CT scans, PET scans and isotope studies.	Benefits shall be at 100% of Scheme tariff limited to R16 891 per family per financial year, where conservative back and neck scans shall be limited to 1 (one) scan per lumbar and cervical spine region per beneficiary and be subject to the aforementioned limit	Benefits shall be at 100% of Scheme tariff limited subject to the following: - MRI scans and CT scans shall be limited to 2 (two) scans per beneficiary, which includes 1 (one) conservative back and neck scan per lumbar and cervical spine region per beneficiary; - PET scans shall be limited to 1 (one) scan per beneficiary; and - Pre-authorisation for any specialised radiology must be obtained from the Scheme or its proxy.		
2.7.9 MHC Back and Neck Programme	Benefits shall be payable at 100% of contracted fee and are applicable to all ages – subject to Pre-authorisation: - Applicable to beneficiaries with serious back or neck problems that may require surgery and use of this programme is in lieu of surgery. - Preferred providers, i.e. DBC or Workability clinics. - The Scheme may identify appropriate participants for evaluation at a DBC or Workability clinic. Based on the first assessment, a rehabilitation treatment plan is drawn up and initiated over an uninterrupted period that will be specified by the provider.			
2.7.10 Rehabilitation after trauma	Benefits shall be payable at 100% of Scheme tariff/cost*.			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
Benefits for rehabilitation shall be aimed at the recovery of impeded vital functions immediately after trauma such as a stroke or heart attack.				