ANNEXURE B.2 – BENEFIT OPTIONS
2021 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 advance:
  - In the event of planned major operations and dental procedures at least 14 (fourteen) days before the event or shorter period where clinically indicated; or
  - 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.
- If a Member or his Dependant(s) receive treatment in a private hospital or day clinic without first obtaining Pre-Authorisation and an authorisation number due to either prior application not made or because a prior application was refused, a R500 surcharge per admission may be imposed whenever an application is approved with retrospective effect.
- 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.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
- 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.				
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 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.			
2.2.4 Treatment of chemical and substance abuse	Benefits shall be at 100% of Scheme tariff/cost*, subject to the following: - Pre-Authorisation; - DSPs; - The length of stay shall be limited to 21 (twenty-one) days for in-hospital or 15 (fifteen) contact sessions for out-patient psychotherapy per condition, per beneficiary per financial year; OR - Limited to R32 299 per beneficiary per financial year.			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.5 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*.			
2.2.6 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.			
2.2.7 Blood transfusion	Blood, operators' fees, transport charges and apparatus payable at 100% of Scheme tariff/cost*.			
2.2.8 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. - 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.			
2.2.8.1 Dental and oral surgery (in and/or out of hospital):	Benefits shall be at 100% of Scheme tariff limited to R8 075 per family per financial year for the following procedures	Benefits shall be at 100% of Scheme tariff limited to R13 419 per family per financial year for the following procedures	Benefits shall be at 100% of Scheme tariff limited to R16 862 per family per financial year for the following procedures	Benefits shall be at 100% of Scheme tariff limited to R20 187 per family per financial year for the following procedures performed either in or out of hospital:

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	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; - Pre-prosthetic (preparatory to dental prosthetics) surgery; - Orthodontic related / orthognathic surgery.	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; - Pre-prosthetic (preparatory to dental prosthetics) surgery; - Orthodontic related / orthognathic surgery.	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; - Pre-prosthetic (preparatory to dental prosthetics) surgery; - Orthodontic related / orthognathic surgery.	- 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; - Pre-prosthetic (preparatory to dental prosthetics) surgery; - Orthodontic related / orthognathic surgery.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.8.2 Major medical maxilla-facial surgery	Benefits shall be at 100% of Scheme tariff limited to R13 062 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, secondary oro-nasal fistula, faciostenosis); - Internal TM joint surgery (condylectomy, arthrocentesis, arthroplasty, total joint reconstruction);	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
	- Salivary gland surgery (removal of gland or salivary stone); - Life threatening sepsis (Ludwig's angina); and - Confirmed oral cancer.			
2.2.9 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.			
2.2.9.1 Prosthesis – Internal Prosthesis surgically implanted during operations for the replacement of parts of the human body for functional medical reasons, including delivery systems and related items.	Benefits shall not be pro-rated and shall be paid at 100% of Scheme tariff/cost* limited to the over-all limit of R90 246 per family per financial year.	Benefits shall not be pro-rated and shall be paid at 100% of Scheme tariff/cost* limited to the over-all limit of R115 895 per family per financial year.	Benefits shall not be pro-rated and shall be paid at 100% of Scheme tariff/cost* limited to the over-all limit of R116 489 per family per financial year.	Benefits shall not be pro-rated and shall be paid at 100% of Scheme tariff/cost* limited to the over-all limit of R134 419 per family per financial year. Sub-limits per beneficiary per financial year:

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R32 892; - Pacemaker dual chamber limited to R56 167; - Endovascular and catheter based procedures and delivery mechanisms – no benefit; - Spinal prosthesis shall be limited to R32 892; - Artificial disks, spacers and similar devices – no benefit; - Drug eluting stent – no benefit apart from PMB conditions and DSP products only; - Mesh shall be limited to R12 349;	Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R43 460; - Pacemaker dual chamber shall be limited to R62 637; - Spinal prosthesis including artificial disk (single level based) shall be limited to R58 102; - Drug eluting stent shall be limited to R18 999; - Mesh shall be limited to R18 999; - Gynaecological/Urological prosthesis shall be limited to R14 190; - Lens implant shall be limited to R12 184 a lens per eye;	Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R43 580; - Pacemaker dual chamber shall be limited to R62 637; - Spinal prosthesis including artificial disk (single level based) shall be limited to R58 212; - Drug eluting stent shall be limited to R18 999; - Mesh shall be limited to R18 999; - Gynaecological/Urological prosthesis shall be limited to R14 249; - Lens implant shall be limited to R12 184 a lens per eye;	- Vascular prosthesis shall be limited to R49 873; - Pacemaker dual chamber shall be limited to R62 637; - Spinal prosthesis including artificial disk (single level based) shall be limited to R67 215; - Drug eluting stent shall be limited to R22 384; - Mesh shall be limited to R19 712; - Gynaecological/Urological prosthesis shall be limited to R16 269; - Lens implant shall be limited to R18 014 a lens per eye; - Hip prosthesis and other major joints shall be limited to R60 144;

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Gynaecological/Urological prosthesis shall be limited to R8 906; - Lens implant shall be limited to R6 769 a lens per eye; - Functional prosthesis – items utilised towards treating or supporting a bodily function - shall be limited to R16 209.	- Hip prosthesis and other major joints shall be limited to R52 188; - Knee prosthesis shall be limited to R60 560; - Other minor joints shall be limited to R22 502; and - Functional – items utilised towards treating or supporting a bodily function - shall be limited to R17 634.	- Hip prosthesis and other major joints shall be limited to R52 248; - Knee prosthesis shall be limited to R60 857; - Other Minor joints shall be limited to R22 502; and - Functional – items utilised towards treating or supporting a bodily function - shall be limited to R18 999.	- Knee prosthesis shall be limited to R69 644; - Other Minor joints shall be limited to R22 384; and - Functional – items utilised towards treating or supporting a bodily function - shall be limited to R19 712.
2.2.9.2 Prosthesis – External: Prosthesis used after operations for the replacement of parts of the human body for functional medical reasons, including delivery systems and related items. A list of prosthesis covered by the Scheme can be requested from the Scheme.	Benefits shall be at 100% of Scheme tariff limited to R22 918 per family per financial year: - 2 (two) quotations may be required; - Preferred providers or DSPs; and - Artificial limbs are limited to 1 (one) limb every 60	Benefits shall be at 100% of Scheme tariff limited to R27 311 per family per financial year: - 2 (two) quotations may be required; - Preferred providers or DSPs; and - Artificial limbs are limited to 1 (one) limb every 60	Benefits shall be at 100% of Scheme tariff limited to R27 431 per family per financial year: - 2 (two) quotations may be required; - Preferred providers or DSPs; and - Artificial limbs are limited to 1 (one) limb every 60	Benefits shall be at 100% of Scheme tariff limited to R30 993 per family per financial year: - 2 (two) quotations may be required; - Preferred providers or DSPs; and - Artificial limbs are limited to 1 (one) limb every 60 (sixty)

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	(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 2.6.4.	(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 2.6.4.	(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 2.6.4.	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 2.6.4.
2.2.9.3 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:	Not applicable		

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Hip prosthesis and other major joints shall be limited to R33 486; - Knee prosthesis shall be limited to R44 530; and - Other minor joints shall be limited to R13 834.			
2.2.10 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.			
2.2.11 Pathology during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*.			
2.2.12 Basic radiology during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*.			
2.2.13 Specialised diagnostic imaging during hospitalisation	Benefits shall be at 100% of Scheme tariff for MRI scans, CT scans and isotope studies.			
2.2.14 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.			
2.2.15 Mammary surgery For breast cancer patients	No benefit for non-cancer breast.	Benefit shall be at 100% of Scheme tariff/cost* up to R36 750 for symmetrising surgery on breast cancer patients for the non-affected breast. Benefit is subject to Pre-Authorisation and funding guideline.		

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.16 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.			
2.2.17 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.			
2.2.18 Confinements	Benefits shall be at 100% of Scheme tariff/cost*, even if the baby dies before registration, for the following: - Medical practitioners; - 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.			
2.2.19 Refractive surgery and all types of procedures to improve or stabilise vision, except for cataracts	Benefits shall be at 100% of Scheme tariff limited to R8 977 per eye, subject to Pre-Authorisation and protocols.	Benefits shall be at 100% of Scheme tariff limited to R9 380 per eye, subject to Pre-Authorisation and protocols.	Benefits shall be at 100% of Scheme tariff limited to R10 094 per eye, subject to Pre-Authorisation and protocols.	

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.20 Supplementary services during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*, provided that the claim is related to the hospital admission of the patient and is in line with the Scheme funding guidelines and protocols, for supplementary services which include services rendered by physiotherapists, masseurs, chiropractors, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech therapists, biokinetics, stoma therapist and social workers.			
2.2.21 Alternatives to hospitalisation	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.			
2.2.22 Palliative care and home-based care in lieu of hospitalisation	Benefits shall be at 100% of Scheme tariff/cost* limited to R30 000 per beneficiary per financial year, subject to Pre-Authorisation.	Benefits shall be at 100% of Scheme tariff/cost* limited to R45 000 per beneficiary per financial year, subject to Pre-Authorisation.		
2.2.23 Ambulance and emergency evacuation services	Benefits shall be subject to: - Provision of benefits by ER24, 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.			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.24 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 Bryte Insurance Company Limited, as the Scheme's capitated preferred provider for international travel insurance. - Cover that is limited to R10 million per beneficiary per trip and includes emergency medical expenses and evacuation costs. - Beneficiaries have access to 90 (ninety) days cover per trip, calculated from the date of departure. - 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.			
1.2.25 Day procedures at a day hospital facility	Day procedures at a day hospital facility shall be funded at 100% of Scheme tariff/cost[*], subject to: - Pre-Authorisation; - Protocols and funding guidelines; and - DSPs for PMBs Where procedures are done in a private hospital, funding shall be at day procedure tariff and may be subject to co-payments.			
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 PMB biological and non-PMB biological medicine costs shall be paid from the applicable biological and other high-cost 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 70% of Scheme tariff with a 30% co-payment.	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 75% of Scheme tariff with a 25% co-payment.	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 80% of Scheme tariff with a 20% co-payment.	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 85% of Scheme tariff with a 15% co-payment.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	Payment shall be at Scheme tariff limited to M = R6 650 and M1+ = R13 299 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** - Migraine prophylaxis Subject to:	Payment shall be at Scheme tariff limited to M = R9 144 and M1+ = R18 287 for the following 18 (eighteen) non-CDL conditions: - Acne - Allergic rhinitis - Ankylosing Spondylitis - Alzheimer's disease - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Collagen diseases - Dermatomyositis - Eczema	Payment shall be at Scheme tariff limited to M = R14 749 and M1+ = R29 496 for the following 19 (nineteen) non-CDL conditions: - Acne - Allergic rhinitis - Ankylosing Spondylitis - Alzheimer's disease - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Collagen diseases - Dermatomyositis - Eczema	Payment shall be at Scheme tariff limited to M = R19 889 and M1+ = R39 958 for the following 28 (twenty-eight) non-CDL conditions: - Acne - Allergic rhinitis - Ankylosing Spondylitis - Alzheimer's disease - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Blepharospasm - Collagen diseases - Dermatomyositis - Dystonia** - for ongoing or long-term chronic use - Eczema

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.	- Gastro Oesophageal Reflux Disease (GORD)** - Gout Prophylaxis** - Major Depression** - Migraine prophylaxis - Obsessive Compulsive Disorder - Osteoarthritis - Osteoporosis** - Paget's disease - Psoriasis - 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.	- Gastro Oesophageal Reflux Disease (GORD)** - Gout Prophylaxis** - Major Depression** - Migraine prophylaxis - Neuropathy - Obsessive Compulsive Disorder - Osteoarthritis - Osteoporosis** - Paget's disease - Psoriasis - Urinary incontinence Subject to: - Prior application and approval by the Scheme and benefits shall be from the date on which the application was	- Gastro Oesophageal Reflux Disease (GORD)** - Gout Prophylaxis** - Hypopituitarism - Major Depression** - Migraine prophylaxis - Motor neuron disease - Neuropathy - Obsessive Compulsive Disorder - Osteoarthritis - Osteoporosis** - Paget's disease - Polyarthritis nodosa - Psoriasis - Psoriatic arthritis - Scleroderma - Sjogren's disease - Trigeminal neuralgia - Urinary incontinence Subject to:

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
			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.
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 65% of Scheme tariff with a 35% co-payment. Subject to: Prior application and approval by the Scheme.	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 70% of Scheme tariff with a 30% co-payment. Subject to: Prior application and approval by the Scheme.	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. Subject to: Prior application and approval by the Scheme.	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. Subject to: Prior application and approval by the Scheme.
2.3.3 Biologicals and other high-cost medicine:		Subject to pre-approval, the benefits shall be paid at	Subject to pre-approval, the benefits shall be paid at	Subject to pre-approval, the benefits shall be paid at 100%

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
A 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; and A high cost medicine is any costly medicine that the Scheme has classified as such and is only covered under this benefit, i.e. the high cost benefit.	Scheme pre-approval is required and 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.	100% of Scheme tariff/cost* with a maximum of R166 132 per beneficiary per financial year.	100% of Scheme tariff/cost* with a maximum of R332 485 per beneficiary per financial year.	of Scheme tariff/cost* with a maximum of R492 077 per beneficiary per financial year.
2.3.4 Acute medicine	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall subject to the overall day-to-day limit and the following maxima 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 subject to the overall day-to-day limit and the following maxima 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 subject to the overall day-to-day limit and the following maxima per financial year:	Benefits shall be subject to the overall day-to-day limit and the following maxima per financial year: M = R8 906 and M1+ = R13 834 Benefits shall be for:

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	M = R2 352 and M1+ = R4 869 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 herbal remedies without nappi code(s) shall be paid from the Vested Medical Savings Account.	M = R4 869 and M1+ = R9 737 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 herbal remedies without nappi code(s) shall be paid from the Vested Medical Savings Account.	M = R1 544 and M1+ = R3 800 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. - Benefits for homeopathic remedies, injections and herbal remedies without nappi code(s) shall be	- 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
			paid from the Vested Medical Savings Account.	
2.3.5 Over-the-counter (OTC) medicine The member must 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 R683 per family per financial year, paid at 100% of Scheme tariff from the PMSA. Benefit includes 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 medicine benefits through the Acute medicine benefit, or 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 R683 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 medicine purchases, in excess of the aforementioned set limit, will accumulate to a self-payment gap.			100% of the Scheme tariff, subject only to funds being available in the PMSA. Benefit includes purchases of sunscreen, vitamins and minerals with nappi codes on the Scheme's formulary.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	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.			
2.4. PREVENTATIVE CARE AND WELLNESS BENEFITS	Benefits shall be at 100% of Scheme tariff.			
2.4.1 Influenza vaccine	1 (one) vaccine per beneficiary per financial year.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
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 Paediatric immunisations	Paediatric vaccines according to the State recommended programme for babies and children.			
2.4.5 Female contraceptives	Applicable to all females of childbearing age: - Quantity and frequency depending on product up to the maximum of R2 315 per beneficiary per financial year, which includes all items classified in category of female contraceptives. - Mirena device – 1 (one) device in 60 (sixty) months.			
2.4.6 Back and neck preventative programme	Applicable to all ages – subject to Pre-Authorisation: - Preferred providers, i.e. DBC or Workability clinics. - Applicable to beneficiaries with serious spinal and/or back problems that may require surgery and use of this programme is in lieu of surgery. - 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.			
2.4.7 Preventative dentistry	Benefits are applicable per beneficiary:			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	1. General full mouth examination by a general dentist (incl. gloves and use of sterile equipment for this visit): - 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, twice per financial year. **5. Fluoride treatment:** All ages, twice per financial year. **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.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
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	Males 50 (fifty) years and older: - Once every 24 (twenty-four) months per beneficiary. - To be done at urologist. Urologist consultation paid from the consultation benefit.			
2.4.12 PAP smear	Preventative benefit is subject to: - Females 18 (eighteen) years and older. - Once every 24 (twenty-four) months per beneficiary. - To be done at a gynaecologist or general practitioner. - Consultation fee paid from the consultation benefit, subject to PMBs. Benefits in respect of PMBs for shall be paid from the applicable Scheme benefits.			
2.4.13 Tempo Programme: Apart from the Maternity benefits, the benefits on the Tempo Programme will only be accessed when an adult beneficiary undergoes a health risk assessment.	**1. Health Risk Assessments** Adults beneficiaries - 1 (one) per beneficiary per financial year for beneficiaries 18 (eighteen) years and older. - Biometric screening and lifestyle questionnaire must be completed at Wellness Network pharmacies or onsite at selected Employer Groups. - Except for the Maternity benefits, an adult beneficiary must complete a health risk assessment in order to unlock the rest of the Tempo Programme benefits.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	Child dependants - Growth and development assessments: 3 (three) per beneficiary per financial year for all beneficiaries ages 0 (zero) to 2 (two) years old at Wellness Network pharmacies. - Health assessment at a Wellness Network occupational therapist: 1 (one) per beneficiary per financial year for all beneficiaries 3 (three) to 12 (twelve) years old. - Health assessment at a Wellness Network biokineticist: 1 (one) per beneficiary per financial year for beneficiaries 13 (thirteen) to 17 (seventeen) years old. **2. Family Nutritional Assessments:** 1 (one) family nutritional assessment at a Wellness Network dietician per financial year. **3. Fitness and Nutritional Interventions (pre-approval required):** - 3 (three) individualised dietician consultations per beneficiary per financial year for beneficiaries 18 (eighteen) years and older, at a Wellness Network dietician. - 3 (three) individualised biokinetic consultations per beneficiary per financial year for beneficiaries 18 (eighteen) years and older, at a Wellness Network biokineticists. **4. Maternity benefits:** Benefits shall be at 100% of Scheme tariff per beneficiary per financial year, subject to the following: Consultations: - 9 (nine) antenatal consultations at either a GP/gynaecologist/midwife.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- 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 R100 per claim, once a month, for a maximum of 9 (nine) months.			
2.5 OPTOMETRY BENEFITS	Optometry benefits are available per beneficiary every 24 (twenty-four) months from the date of service. Services rendered by Preferred Provider Negotiators (PPN) 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.			
	Benefits from a PPN network optometrist shall be as follows: - Consultations: 1 (one) per beneficiary at 100% of cost - Spectacle frames or lens enhancements limited to R825 AND - Lenses: standard lenses (i.e. single vision or bifocal or multifocal lenses) at 100% of cost OR			Benefits from a PPN network optometrist shall be as follows: - Consultations: 1 (one) per beneficiary at 100% of cost

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Contact lenses limited to R1 565 Benefits from a non-network provider shall be as follows: - Consultations: 1 (one) per beneficiary limited to R350 - Spectacle frames or lens enhancements limited to R598 AND - Lenses: Single-vision lenses at R210 OR Bifocal lenses at R445 OR Multifocal lenses at R770 - In lieu of glasses Members can opt for contact lenses at R1 565			- Spectacle frames or lens enhancements limited to R825 AND - Lenses: standard lenses (i.e. single vision or bifocal or multifocal lenses) at 100% of cost OR - Contact lenses limited to R1 850 Benefits from a non-network provider shall be as follows: - Consultations: 1 (one) per beneficiary limited to R350 - Spectacle frames or lens enhancements limited to R598 AND - Lenses:

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
				Single-vision lenses at R210 OR Bifocal lenses at R445 OR Multifocal lenses at R770 - In lieu of glasses Members can opt for contact lenses at R1 850
2.6 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. - 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:	The following combined overall limit for day-to-day benefits shall apply per financial year:	The following combined overall limit for day-to-day benefits shall apply per financial year:	The following combined overall limit for day-to-day benefits shall apply per financial year: M = R35 861 and M1+= R57 829

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	M = R10 901 and M1+= R21 801	M = R15 389 and M1+= R30 779	M = R19 237 and M1+= R39 756	
2.6.1 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 245 and M1+ = R4 512	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 394 and M1+ = R8 906		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 640 and M1+ = R9 144
2.6.2 Diabetes primary care consultation	Benefits shall be at 100% of Scheme tariff subject to: - Registration with HaloCare in order to access 2 (two) primary care consultations at Dis-Chem Pharmacies per financial year. - The consultation shall be limited to R360, which will be paid first from the “GP, nurse and specialist consultations” day-to-day benefit maxima and thereafter Scheme risk.			
2.6.3 Basic and specialised dentistry	Basic and specialised dentistry benefits shall be at 100% of Scheme tariff from	Basic and specialised dentistry benefits shall be at 100% of Scheme tariff from	Basic and specialised dentistry benefits shall be at 100% of Scheme tariff from	Basic and specialised dentistry benefits shall be at 100% of Scheme tariff subject to the

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
This benefit covers basic and specialised dentistry not defined under Preventative dentistry benefits or Dental / Oral / Jaw surgical benefits.	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 131 and M1+ = R8 384 Specialised dentistry benefits include: - 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) are	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 = R6 926 and M1+ = R13 852 Specialised dentistry benefits include: - 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) are	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 = R7 463 and M1+ = R13 912 Specialised dentistry benefits include: - 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) are	overall day-to-day limit and the following maxima per financial year: M = R12 454 and M1+ = R21 021 Specialised dentistry benefits include: - 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) are subject to Pre-Authorisation; and - Dental implants, implant costs and all laboratory costs

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	subject to Pre-Authorisation; and - Dental implants, implant costs and all laboratory costs related to the aforementioned services.	subject to Pre-Authorisation; and - Dental implants, implant costs and all laboratory costs related to the aforementioned services.	subject to Pre-Authorisation; and - Dental implants, implant costs and all laboratory costs related to the aforementioned services.	related to the aforementioned services.
2.6.4 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:** - **A fully detailed audiogram;** - **A comprehensive quotation, which includes, *inter alia*, the product name, clinical details (i.e. behind the ear, in the ear,**	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 R11 519 per family per financial year for appliances that shall include any of the items listed below: - Back, leg, arm and neck support; - Wheelchairs;	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 450 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; - Elastic stockings; - Repair work on artificial limbs, wheelchairs, etc.; - Stoma products, and - Oxygen and Diabetic supplies for non-PMB conditions.		Benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R10 450 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; - Elastic stockings; - Repair work on artificial limbs, wheelchairs, etc.;

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
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).**	- Surgical footwear; - Crutches; - Elastic stockings; - Repair work on artificial limbs, wheelchairs, etc.; and - Stoma products, Oxygen and Diabetic supplies for non-PMB conditions.			- Stoma products, - Oxygen supplies and Diabetic supplies for non-PMB conditions; and - Insulin pump consumables.
		Wheelchairs at 100% of Scheme tariff limited to R14 131 per family every 48 (forty-eight) months.		
	Hearing aids and/or repair at 100% of Scheme tariff limited to R8 000 per family once every 24 (twenty-four) months, subject to over-all day-to-day limit. Pre-Authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 2.6.4.	Hearing aids and/or repair at 100% of Scheme tariff limited to R28 796 per beneficiary every 24 (twenty-four) months. Pre-Authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 2.6.4.	Hearing aids and/or repair at 100% of Scheme tariff limited to R32 418 per beneficiary every 24 (twenty-four) months. Pre-Authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 2.6.4.	Hearing aids and/or repair at 100% of Scheme tariff limited to R36 098 per beneficiary every 24 (twenty-four) months. Pre-Authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 2.6.4.
				Insulin pump, excluding consumables, at 100% of Scheme tariff limited to R42 000 per beneficiary every 24

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
				(twenty-four) months. Pre-Authorisation is required.
2.6.5 Supplementary services Benefits includes services rendered by physiotherapists, masseurs, chiropractors, 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), psychiatric treatment, psychologists and social workers.	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 405 and M1+ = R9 144	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 523 and M1+ = R11 102	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 684 and M1+ = R5 640	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 640 and M1+ = R11 102
2.6.6 Wound care benefit Includes dressings and negative pressure wound therapy (NWPT) 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	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	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	Benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R13 774 per family per financial year.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	Scheme tariff subject to the overall day-to-day limit and R3 622 per family per financial year.	Scheme tariff subject to the overall day-to-day limit and R6 887 per family per financial year.	Scheme tariff subject to the overall day-to-day limit and R10 687 per family per financial year.	
2.6.7 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 265 and M1+ = R6 531		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 562 and M1+ = R7 065	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 640 and M1+ = R11 102
2.6.8 Specialised diagnostic imaging MRI scans, CT scans, PET scans and isotope studies.	Benefits shall be at 100% of Scheme tariff limited to R14 606 per family per financial year.	Benefits shall be at 100% of Scheme tariff limited subject to the following: - MRI scans and CT scans shall be limited to 3 (three) scans per beneficiary; - PET scans shall be limited to 1 (one) scan per beneficiary; and - A pre-authorisation for any specialised radiology must be obtained from the Scheme or its proxy.		

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.6.9 Rehabilitation after trauma Benefits for rehabilitation shall be aimed at the recovery of impeded vital functions immediately after trauma such as a stroke or heart attack.	Benefits shall be at 100% of Scheme tariff from the Vested Medical Savings Account.	Benefits shall be payable at 100% of Scheme tariff/cost*.		

* As per the provisions of Rule 2.1.8.