ANNEXURE B.3 – BENEFIT OPTIONS
2021 PULSE RANGE

3.1 GENERAL CONDITIONS OF THE BENEFIT OPTIONS

3.1.1 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.

3.1.2 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.

3.1.3 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.

3.1.4 Granting of benefits for these network restricted benefit options shall be subject to, but not limited to, treatment protocols, funding guidelines, preferred providers and designated service providers (DSP) network, 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.

3.1.5 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.

3.1.6 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.

3.1.7 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.

3.1.8 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):

3.1.8.1 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.

3.1.8.2 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:

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

3.1.8.2.2 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	PULSE1	PULSE2

3.2 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	PULSE1	PULSE2
- The Scheme's list of Hospital Network DSP (contracted private hospitals and 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. - Co-payments: ▪ A co-payment of R3 800 per hospital admission shall apply on all laparoscopic procedures, prostate procedures, prolapsed / incontinence, arthroscopy other than acute trauma and endoscopic investigations. No co-payment shall apply where procedures are performed out of hospital, i.e. in a day clinic or in doctor's rooms. ▪ A co-payment of R11 874 shall apply on the Pulse benefit options for the voluntary use of a non-designated Hospital Network, i.e. where a Member or his Dependant(s) voluntarily choose not to make use of a hospital forming part of the Hospital Network. ▪ Pulse1 benefit option: a co-payment of R500 shall apply for specialist visits without a referral by a Pulse1 Network GP or a specialist registered on the Pulse Specialist Network or a PPN network optometrist to a specialist registered on the Pulse Specialist Network and the voluntary use of non-DSPs.		
3.2.1 Hospitalisation: Pre-authorisation required 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*. DSP Network applies.	
3.2.2 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 3 (three) days.	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.

* As per the provisions of Rule 3.1.8.

<table>
<tr><th>HEALTHCARE SERVICES</th><th>PULSE1</th><th>PULSE2</th></tr>
<tr><td>3.2.3 Treatment in mental health clinics</td><td colspan="2">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.</td></tr>
<tr><td>3.2.4 Treatment of chemical and substance abuse</td><td>Benefits shall be limited to the treatment of PMB conditions and subject to the following:

- Pre-Authorisation;
- DSP Network; and
- 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.</td><td>Benefits shall be at 100% of Scheme tariff/cost*, subject to the following:

- Pre-Authorisation;
- DSP Network;
- 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.</td></tr>
<tr><td>3.2.5 Consultations and procedures:
Consultations, visits, operations, surgical procedures and anaesthetics for surgical procedures during hospitalisation.</td><td colspan="2">Claims submitted by General Practitioners (GPs) and specialists for treatment during hospitalisation shall be paid at 100% of Scheme tariff/cost*.
DSP Network applies.</td></tr>
<tr><td>3.2.6 Organ transplants (in and/or out of hospital):</td><td colspan="2">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 underlined by PMB regulations, and shall be paid at cost.</td></tr>
</table>

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	PULSE1	PULSE2
Pre-authorisation must be obtained.		
3.2.7 Blood transfusion	Blood, operators' fees, transport charges and apparatus payable at 100% of Scheme tariff/cost*.	
3.2.8 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% 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.	
3.2.8.1 Dental and oral surgery (in and/or out of hospital)	No benefit	Benefits shall be at 100% of Scheme tariff limited to 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; - Pre-prosthetic (preparatory to dental prosthetics) surgery; - Orthodontic related / orthognathic surgery.
3.2.8.2 Major medical maxilla-facial surgery	No benefit	100% of Scheme tariff strictly for the following conditions:

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	PULSE1	PULSE2
		- 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.
3.2.9 Prosthesis Benefits	Benefits are subject to the following: - Pre-authorisation; - Preferred providers or DSPs; - Services for non-PMB conditions shall be based on Scheme tariff or contracted fee and may be subject to exclusions for joint replacement surgery; and - 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.	

HEALTHCARE SERVICES	PULSE1	PULSE2
3.2.9.1 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 R53 079 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R26 302; - Pacemaker dual chamber limited to R42 986; - Endovascular and catheter based procedures and delivery mechanisms – no benefit; - Spinal prosthesis shall be limited to R26 302; - 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 R9 619; - Gynaecological/Urological prosthesis shall be limited to R7 944; - Lens implant shall be limited to R5 523 a lens per eye; - Functional prosthesis – items utilised towards treating or supporting a bodily function - shall be limited to R11 281.	Benefits shall not be pro-rated and shall be paid at 100% of Scheme tariff/cost* limited to the over-all limit of R106 277 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R41 086; - Pacemaker dual chamber shall be limited to R55 692; - Spinal prosthesis shall be limited to R41 086; - Artificial disk (single level based) shall be limited to R18 049; - Drug eluting stent shall be limited to R18 049; - Mesh shall be limited to R18 049; - Gynaecological/Urological prosthesis shall be limited to R13 419; - Lens implant shall be limited to R11 519 a lens per eye; - Hip prosthesis and other major joints shall be limited to R49 160; - Knee prosthesis shall be limited to R57 413; - Other Minor joints shall be limited to R21 374; and

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	PULSE1	PULSE2
		- Functional – items utilised towards treating or supporting a bodily function - shall be limited to R17 634.
3.2.9.2 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.	No benefit, except in respect of PMB conditions.	Benefits shall be at 100% of Scheme tariff limited to R25 649 per family per financial year: - 2 (two) quotations may be required; - Preferred providers and 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 3.6.6.
3.2.9.3 Exclusions on joint replacement surgery for non-PMB conditions	No benefit for joint replacement surgery, except for PMBs, subject to the following prosthesis limits at 100% contracted fees: - Hip prosthesis and other major joints shall be limited to R26 956; - Knee prostheses shall be limited to R34 080; and - Other minor joints shall be limited to R12 765.	Not applicable

HEALTHCARE SERVICES	PULSE1	PULSE2
	Functional nasal surgery and surgery procedures where CNS stimulators are used for example epilepsy, Parkinsonism, etc. will be excluded from benefits except for PMB conditions.	
3.2.10 Orthopaedic and medical appliances during hospitalisation Pre-authorisation must be obtained.	Benefits shall be at 100% of Scheme tariff/cost* limited to R6 531 per family per financial year for the items listed below, if prescribed by a medical practitioner and where such a prescription forms part of the in hospital treatment. - Back, leg, arm and neck support; - Crutches; - Surgical footwear (excluding health footwear); - Elastic stockings; - Oxygen, diabetic and stoma aids continually essential for the medical treatment of the patient; and - Medical apparatus continually essential for the medical treatment of the patient.	Benefits shall be at 100% of Scheme tariff/cost* for back, leg, arm and neck support, crutches, surgical footwear (excluding health footwear) and elastic stockings provided before discharge from hospital.
3.2.11 Pathology during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*.	

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	PULSE1	PULSE2
3.2.12 Basic radiology during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*.	
3.2.13 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.	
3.2.14 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.	
3.2.15 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.	
3.2.16 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.	
3.2.17 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.	

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	PULSE1	PULSE2
3.2.18 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.
3.2.19 Refractive surgery and all types of procedures to improve or stabilise vision, except for cataracts	No benefit, except in respect of PMB conditions.	Benefits shall be at 100% of Scheme tariff limited to R9 440 per eye, subject to Pre-Authorisation and protocols.
3.2.20 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.	
3.2.21 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.	
3.2.22 Palliative care and home-based care in lieu of hospitalisation	Benefits shall be at 100% of Scheme tariff/cost* limited to R24 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.

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	PULSE1	PULSE2
3.2.23 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.	
3.2.24 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 notify 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.	
3.2.25 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	

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	PULSE1	PULSE2
	- 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.	
3.2.26 Co-payments	- Pulse1 benefit option: A co-payment of R3 800 per hospital admission shall apply on all laparoscopic procedures, prostate procedures, prolapsed / incontinence, arthroscopy other than acute trauma and endoscopic investigations. No co-payment shall apply where procedures are performed out of hospital, i.e. in a day clinic or in doctor's rooms. - Pulse1 benefit option: a co-payment of R500 shall apply for specialist visits without a referral by a Pulse1 Network GP or a specialist registered on the Pulse Specialist Network or a PPN network optometrist and the voluntary use of non-DSPs. - A co-payment of R11 874 shall apply on the Pulse1 and Pulse2 benefit options for the voluntary use of a non-designated Hospital Network, i.e. where a Member or his Dependant(s) voluntarily choose not to make use of a hospital forming part of the Hospital Network.	

3.3. 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.
- 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 - Members choosing the Network options are required to make use of Scheme-contracted pharmacies to obtain their medicine.

HEALTHCARE SERVICES	PULSE1	PULSE2
- 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.		
3.3.1 Chronic medicine not listed on the chronic disease list ("non-CDL medicine")	No benefit	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. Benefit shall be at Scheme tariff limited to M = R6 887 and M1+ = R13 774 for the following 16 (sixteen) non-CDL conditions: - Acne - Allergic rhinitis - Alzheimer's disease - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Eczema

HEALTHCARE SERVICES	PULSE1	PULSE2
		- 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 received by the Scheme or its proxy.
3.3.2 Medicine for PMB conditions including the conditions listed on the chronic disease list (CDL)	Medicine on the formulary shall be covered at 100% of Scheme tariff/cost* with no co-payment and voluntary use of non-formulary medicine shall be covered at 60% of Scheme tariff with a 40% co-payment.	Medicine on the formulary shall be covered at 100% of 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.

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	PULSE1	PULSE2
	Subject to: - Prior application and approval by the Scheme.	Subject to: - Prior application and approval by the Scheme.
3.3.3 Biologicals and other high-cost medicine: 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.	Subject to pre-approval, the benefits shall be paid at 100% of Scheme tariff/cost* with a maximum of R156 743 per beneficiary per financial year.
3.3.4 Acute medicine	Benefits shall be at 100% of Scheme tariff, for: - Medicine on the formulary prescribed out of a hospital by a medical practitioner, a dentist or a person authorised thereto by law. - No benefit shall apply to non-formulary acute medicine.	Benefits shall be at 100% of Scheme tariff, for: - Medicine prescribed out of a hospital by a medical practitioner, a dentist or a person authorised thereto by law. - Registered homeopathic remedies, injections and herbal remedies with nappi code(s).

HEALTHCARE SERVICES	PULSE1	PULSE2
		- Benefits shall be subject to the overall day-to-day benefit and the following maxima per financial year: M = R4 572 and M1+ = R9 262
3.3.5 Over-the-counter (OTC) medicine	Benefits shall be at 100% of Scheme tariff up to the limit of R387 per family per annum, at a preferred provider pharmacy network. Benefit includes purchases of sunscreen, vitamins and minerals with nappi codes on the Scheme's formulary.	Benefits shall be at 100% of Scheme tariff up to the limit of R608 per family per annum, at a preferred provider pharmacy network. Benefit includes purchases of sunscreen, vitamins and minerals with nappi codes on the Scheme's formulary.
3.4. PREVENTATIVE CARE AND WELLNESS BENEFITS	Benefits shall be at 100% of Scheme tariff.	
3.4.1 Influenza vaccine	1 (one) vaccine per beneficiary per financial year.	
3.4.2 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.	
3.4.3 Travel vaccinations	Bestmed provides cover for certain mandatory travel vaccines for typhoid, yellow fever, tetanus, meningitis, hepatitis and cholera from Scheme risk benefits.	
3.4.4 Paediatric immunisations	Paediatric vaccines according to the State recommended programme for babies and children.	

HEALTHCARE SERVICES	PULSE1	PULSE2
3.4.5 Female contraceptives	Applicable to all females of child bearing 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.	
3.4.6 Mammogram	Females 40 (forty) years and older - once every 24 (twenty-four) months: - Only for tariff code 34100; and - Must be referred by a Network GP, a specialist that is part of the Pulse Specialist Network.	
3.4.7 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.	
3.4.8 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).	
3.4.9 Tempo Programme: Apart from the Maternity benefits, the benefits on the Tempo Programme will only be accessed when an adult beneficiary	**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.	

<table>
<tr><th>HEALTHCARE SERVICES</th><th>PULSE1</th><th>PULSE2</th></tr>
<tr><td>undergoes a health risk assessment.</td><td colspan="2">- Except for the Maternity benefits, an adult beneficiary must complete the abovementioned health risk assessment in order to unlock the rest of the Tempo Programme benefits.

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.</td></tr>
<tr><td></td><td>4. Maternity benefits</td><td>4. Maternity benefits</td></tr>
</table>

HEALTHCARE SERVICES	PULSE1	PULSE2
	Benefits shall be at 100% of Scheme tariff at Network Providers only for the following: 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 R100 per claim, once a month, for a maximum of 9 (nine) months.	Benefits shall be at 100% of Scheme tariff subject to the following benefits: Consultations: - 9 (nine) antenatal consultations at either a GP/Pulse DSP Network 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 R100 per claim, once a month, for a maximum of 9 (nine) months.
3.5 OPTOMETRY BENEFITS	Optometry benefits are available per beneficiary every 24 (twenty-four) months from the date of service.	

<table>
<tr><th>HEALTHCARE SERVICES</th><th>PULSE1</th><th>PULSE2</th></tr>
<tr><td rowspan="2"></td><td colspan="2">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.</td></tr>
<tr><td>Services may only be obtained from a PPN network optometrist. Benefits shall be as follows:
- Consultations at a network provider: 1 (one) per beneficiary at 100% of cost
- Spectacle frames or lens enhancements limited to R225 at PPN providers
AND
- Lenses:
Single-vision lenses limited to R210 at PPN providers
OR
Bifocal lenses limited to R445 at PPN providers
- In lieu of glasses Members can opt for contact lenses, limited to R630 at PPN providers</td><td>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 at 100% of cost from PPN
OR
- 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 limited to R210
OR
Bifocal lenses limited to R445
OR
Multifocal lenses limited to R770</td></tr>
</table>

HEALTHCARE SERVICES	PULSE1	PULSE2
		- In lieu of glasses Members can opt for contact lenses, limited to R1 565
3.6 OUT-OF-HOSPITAL BENEFITS	- No Personal Medical Savings Account. - Full cross subsidisation between Members shall apply without an annual limit. - Benefits may be subject to the annual maxima for the Member with his Dependant(s) and/or as provided for on the benefit.	
	The Scheme designated health care providers to provide primary healthcare services/day-to-day services to Members through the Bestmed Pulse1 Network. Members may only visit service providers registered on the Pulse1 Network.	The Scheme designated health care providers to provide certain day-to-day benefits, through the Bestmed Pulse2 Network and Specialist Designated Service Provider (DSP) Network, to Members. Members may only visit service providers registered on the Pulse2 Network. The following combined overall limit for day-to-day benefits shall apply per financial year: M = R14 546 and M1+= R28 914
3.6.1 GP Consultations Consultations, visits, diagnostic examinations, injections with General Practitioners (GPs).	Benefits shall be at 100% of Scheme tariff/cost* for consultations, visits and treatments by GPs registered on the Pulse1 Network for the following: - Unlimited medically necessary consultations for basic primary care; and	Benefits shall be at 100% of Scheme tariff/cost* for unlimited medically necessary consultations, visits and treatments by GPs.

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	PULSE1	PULSE2
	- Specified minor trauma treatment, including stitches, excision and repair, drainage of abscess and limb cast.	
3.6.2 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.	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 day-to-day benefit maxima and thereafter Scheme risk.
3.6.3 Out-of-network or casualty visits	Every family qualifies for out-of-network GP and casualty visits: - Benefits shall be at 100% of Scheme tariff/cost* limited to R1 425 per family per year. - All radiology and pathology investigations at the casualty unit, that fall within the primary care radiology and pathology benefit schedule, will be included in this limit. - In the event where the family elects to utilise State facilities for emergency visits, such emergency visits shall be unlimited, in addition to the benefits to which the family is already entitled to. - The Member shall pay for the visit first and then claim back from the Scheme.	Every family qualifies for casualty visits: - Benefits shall be at 100% of Scheme tariff/cost* up to R1 544 per family per year, subject to the overall day-to-day limit. - All radiology and pathology investigations that fall within the primary care radiology and pathology benefit schedule will be included in this limit. - The Member shall pay for the visit upfront and then claim back from the Scheme.

<table>
<tr><th>HEALTHCARE SERVICES</th><th>PULSE1</th><th>PULSE2</th></tr>
<tr><td>3.6.4 Specialist visits</td><td>Benefits shall only be considered if referred by a Pulse1 Network GP or a specialist registered on the Pulse Specialist Network or a PPN provider to a specialist on the Pulse Specialist Network and shall be subject to the following:

- Pre-approval by the Scheme;
- The Scheme treatment protocol and clinical funding guidelines (which includes minor procedures done in specialist rooms and all consumable used);
- A co-payment of 40% shall apply if non-formulary medicine is prescribed by the specialist;
- In respect of PMB conditions, a co-payment of R500 shall apply for visits without a referral by a Pulse1 Network GP or a specialist registered on the Pulse Specialist Network or a PPN provider to a specialist registered on the Pulse Specialist Network and the voluntary use of non-DSPs; and
- Benefits shall be at 100% of Scheme tariff limited to the following maxima per financial year:

M = R1 187 and M1+= R1 782</td><td>Specialist visits shall only be considered if referred by a GP or a specialist registered on the Pulse Specialist Network or a PPN provider to a specialist on the Pulse Specialist Network.

Benefits shall be at 100% of Scheme tariff limited to the following maxima per financial year which shall be subject to the overall annual day-to-day limit:

M = R3 207 and M1+= R6 175</td></tr>
</table>

HEALTHCARE SERVICES	PULSE1	PULSE2

3.6.5 Basic and specialised dentistry	Benefits shall be at 100% of Scheme tariff when clinically appropriate, subject to a designated service provider, the Pulse Dental Network approved tariff list and conditions, as well as the following provisions:
	- 2 (two) consultations for full mouth examination per beneficiary per financial year, subject to the Scheme's list of dental codes;
	- Extractions if clinically necessary;
	- Preventative treatment once every 6 (six) months per beneficiary including scaling and polishing and fluoride treatment;
	- 1 (one) set of dentures per family per 24 (twenty-four) months. Benefits shall be subject to a co-payment of 20% (twenty percent) and the use of accredited dental laboratories; and
	- No benefits shall apply for specialised dentistry.
		Benefits for basic and specialised dentistry are subject to the following provisions from the Pulse Dental Network provider and accredited dental laboratories in accordance with the Pulse2 list of codes:
		- Only basic primary care according to a network approved tariff list shall be covered;
		- Consultations, extractions, fillings, scaling and polishing, and root canal treatment at a preferred provider;
		- Specialised dentistry benefits include:
		  - Prosthodontics services (crowns, bridges, inlays, veneers and dentures);
		  - Periodontics services (gum and related problems);
		  - 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 related to the aforementioned services.

HEALTHCARE SERVICES	PULSE1	PULSE2
		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 303 and M1+ = R9 262 The dental benefit excludes the following: - Orthodontic therapy for patients older than 21 (twenty-one) years; - Complications with removable dentures; and - MRI and CT scans for any dento-alveolar procedure.
3.6.6 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;**	No benefit	Benefits shall be at 100% of Scheme tariff limited to R10 331 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, wheel chairs, etc.; - Stoma products, and - Oxygen and Diabetic supplies for non-PMB conditions.

HEALTHCARE SERVICES	PULSE1	PULSE2
- **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).**		Wheel chairs at 100% of Scheme tariff limited to R13 299 per family every 48 (forty-eight) months. Hearing aids and/or repair at 100% of Scheme tariff limited to R28 736 per beneficiary every 24 (twenty-four) months, subject to: - Pre-Authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 3.6.6; and - The use of a preferred provider appointed by the Scheme.
3.6.7 Supplementary services Benefits includes services rendered by physiotherapists, masseurs, chiropractors, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech therapists,	No benefit	Homeopathic benefits including consultations, shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R4 275 and M1+ = R8 490

HEALTHCARE SERVICES	PULSE1	PULSE2
biokinetics, private nursing (stoma therapy nursing, obtaining of specimen, observations and administration of medication, immunisations and IV's), psychiatric treatment, psychologists, social workers, homeopaths and acupuncture.		
3.6.8 Wound care benefit Includes dressings and negative pressure wound therapy (NWPT) treatment and nursing services out of hospital.	No benefit	Benefits shall be at 100% of Scheme tariff limited to R9 975 per family per financial year.
3.6.9 Basic radiology and pathology	Standard diagnostic imaging and pathology services requested by a Pulse1 Network GP at 100% of Scheme tariff, subject to the following: - Standard diagnostic imaging according to a list of codes approved by the Scheme; and - Basic pathology according to a list of codes approved by the Scheme and subject to the Bestmed Pathology Network.	Benefits shall be at 100% of the Scheme tariff, limited to the overall annual day-to-day limit, for pathology and standard diagnostic services requested by a GP or a specialist that is part of the Pulse Specialist Network provided that: - Pathology benefits are subject to the Bestmed Pathology Network;

HEALTHCARE SERVICES	PULSE1	PULSE2
		- Standard diagnostic imaging: only black and white x-rays in single or two dimensional views of limbs, spinal column and abdomen will be covered; and - Protocol and tariff lists or benefit schedules apply and no benefit shall apply if the tariffs are not on the approved tariff lists or benefit schedules.
3.6.10 Specialised Diagnostic Imaging MRI scans, CT scans, PET scans and isotope studies.	No benefit	100% of Scheme tariff subject to the following benefits: - 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.