ANNEXURE B.3 – BENEFIT OPTIONS
2023 RHYTHM 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.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2

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 the event of planned major operations and dental procedures, Members are advised to obtain Pre-authorisation at least 2 (two) weeks in advance to ensure that the Member is aware of applicable benefits, limits, network restrictions, etc., before the event.
  - In an emergency, on the 1st (first) working day after admission to a hospital, or at the first reasonable opportunity as may be determined by the Scheme.
- Late authorisations will be subject to, but not limited to, clinical review, application of rules, benefits, protocols, funding guidelines, as well as the PMB status of the services rendered.
- If Pre-authorisation and an authorisation number have been obtained for treatment in a private hospital or day clinic but the treatment cost exceeds the authorised benefits, only the benefits of the authorised treatment cost shall be granted and the Member shall be liable for payment of the excess to the service provider, unless if the excess costs were as a direct result of treatment received and necessary for the beneficiary and authorisation could not be obtained in time.
- No benefits in respect of MRI scans and computer tomographic studies shall be granted if an authorisation number has not been obtained in advance or, in an emergency, on the 1st (first) working day after admission to a hospital, by the Scheme or its proxy.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
- Full cross subsidisation between Members shall apply without an annual limit. - 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 R13 078 shall apply on the Rhythm1 and Rhythm2 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.		
3.2.1 Hospitalisation: Pre-authorisation required for accommodation (hospital stay) in a general ward, intensive-care and high-care unit, theatre and material.	Benefits shall be limited to the treatment of PMB conditions and to DSP Network.	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.	
3.2.3 Biological medicine during hospitalisation Biological medicine is a substance that is made from a living organism or its products and is used in the prevention, diagnosis, or treatment of acute and chronic diseases.	Benefits shall be limited to the treatment of PMB conditions and to DSP Network.	Benefits shall be at 100% of Scheme tariff/cost*, subject to pre-approval and limited to R15 855 per family per financial year.

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
3.2.4 Treatment in mental health clinics	Benefits shall be limited to the treatment of PMB conditions at DSPs and subject to the length of stay limited to 21 (twenty-one) days per beneficiary per financial year and Pre-authorisation.	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.
3.2.5 Treatment of chemical and substance abuse	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.	
3.2.6 Consultations and procedures: Consultations, visits, operations, surgical procedures and anaesthetics for surgical procedures during hospitalisation. Pre-authorisation must be obtained.	Benefits shall be limited to the treatment of PMB conditions and to DSP Network.	Claims submitted by General Practitioners (GPs) and specialists for treatment during hospitalisation shall be paid at 100% of Scheme tariff/cost*. DSP Network applies.
3.2.7 Organ transplants (in and/or out of hospital): Pre-authorisation must be obtained.	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules underlined by PMB regulations, and shall be paid at cost.	
3.2.8 Blood transfusion	Blood, operators' fees, transport charges and apparatus payable at 100% of Scheme tariff/cost*.	

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
3.2.9 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.	
3.2.9.1 Dental and oral surgery (in and/or out of hospital)	No benefit, except in respect of PMB conditions.	
3.2.9.2 Major medical maxilla-facial surgery	No benefit, except in respect of PMB conditions.	
3.2.10 Prosthesis Benefits	Benefits are subject to the following: - Pre-authorisation; - Limited to DSPs only; - 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	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	RHYTHM1	RHYTHM2
	D.1 of these Rules as per PMB regulations.	
3.2.10.1 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 be limited to the treatment of PMB conditions and DSPs. Benefits shall not be pro-rated and shall be paid at 100% of Scheme tariff/cost* limited to the over-all limit of R58 461 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R50 000; - Pacemaker dual chamber limited to R47 344; - Endovascular and catheter-based procedures and delivery mechanisms – no benefit;	Benefits shall not be pro-rated and shall be paid at 100% of Scheme tariff/cost* limited to the over-all limit of R58 461 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R50 000; - Pacemaker dual chamber limited to R47 344; - Endovascular and catheter-based procedures and delivery mechanisms – no benefit; - Spinal prosthesis including artificial disk (single level based) shall be limited to R28 968; - Spacers and similar devices – no benefit; - Drug eluting stent – no benefit apart from PMB conditions and DSP products only; - Mesh shall be limited to R10 594; - Gynaecological/Urological prosthesis shall be limited to R8 750;

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	- Spinal prosthesis including artificial disk (single level based) shall be limited to R28 968; - Spacers and similar devices – no benefit; - Drug eluting stent – no benefit apart from PMB conditions and DSP products only; - Mesh shall be limited to R10 594; - Gynaecological/Urological prosthesis shall be limited to R8 750; - Lens implant shall be limited to R6 083 a lens per eye; - Functional prosthesis – items utilised towards treating or supporting a bodily function - shall be limited to R31 000.	- Lens implant shall be limited to R6 083 a lens per eye; - Functional prosthesis – items utilised towards treating or supporting a bodily function - shall be limited to R31 000.
3.2.10.2 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	No benefit, except in respect of PMB conditions.	

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
of prostheses covered by the Scheme can be requested from the Scheme.		
3.2.10.3 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 R29 689; - Knee prosthesis shall be limited to R37 536; and - Other minor joints shall be limited to R14 059. 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.	
3.2.11 Mammary surgery For breast cancer	Treatment of the unaffected (non-cancerous) breast shall be limited to PMB provisions and is subject to Pre-authorisation and funding guidelines.	
3.2.12 Orthopaedic and medical appliances during hospitalisation Pre-authorisation must be obtained.	Benefits shall be limited to the treatment of PMB conditions and DSPs for back, leg, arm and neck support, crutches, surgical footwear (excluding health footwear) and elastic stockings provided before discharge from hospital.	Benefits shall be at 100% of Scheme tariff/cost* limited to R7 194 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);

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
		- 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.
3.2.13 Pathology during hospitalisation	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.	Benefits shall be at 100% of Scheme tariff/cost*.
3.2.14 Basic radiology during hospitalisation	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.	Benefits shall be at 100% of Scheme tariff/cost*.

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
3.2.15 Specialised diagnostic imaging during hospitalisation MRI and CT scans, magnetic resonance cholangiopancreatography (MRCP), whole body radioisotope. PET scans excluded. = Pre-authorisation required.	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.	Benefits shall be at 100% of Scheme tariff for MRI scans, CT scans and isotope studies, subject to Pre-authorisation.
3.2.16 Oncology benefits (in or out of hospital) Pre-authorisation required.	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.	Oncology Programme. Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.
3.2.17 Peritoneal dialysis and haemodialysis (in or out of hospital) Pre-authorisation required.	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.	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
3.2.18 HIV/AIDS benefits (in or out of hospital) Pre-authorisation required.	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.	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.
3.2.19 Confinements	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, and emergency caesarean sections (C-sections) 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.	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

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
		- 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.
3.2.20 Refractive surgery and all types of procedures to improve or stabilise vision, except for cataracts Pre-authorisation required.	No benefit, except in respect of PMB conditions	
3.2.21 Supplementary Services during hospitalisation	Benefits shall be limited to the treatment of PMB conditions and DSPs, 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, osteopaths, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech	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, osteopaths, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech therapists, biokinetics, stoma therapist and social workers.

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	therapists, biokinetics, stoma therapist and social workers.	
3.2.22 Alternatives to hospitalisation Pre-authorisation required.	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.	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.
3.2.23 Palliative care and home-based care in lieu of hospitalisation Pre-authorisation required.	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.	Benefits shall be at 100% of Scheme tariff/cost* limited to R63 420 per beneficiary per financial year, subject to Pre-authorisation and treatment plan.
3.2.24 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.	

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	- 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.	
3.2.25 International emergency medical cover	In addition to the provisions for foreign claims referred to in Rule 16.12 of the registered Bestmed Rules, the Member and his Dependant(s) qualify for additional benefits which shall be at 100% contracted tariff subject to the following: - Provision of benefits by Europ Assistance SA, as the Scheme's capitated preferred provider for international travel insurance. - Cover for leisure and business travel for emergency medical and related expenses: ▪ Leisure travel is limited to 45 (forty-five) days and R500 000 cover for travelling to the United States of America (USA) for a family i.e. Member and Dependant(s). All other countries are covered up to 90 (ninety) days for R3 million for a family i.e. Member and Dependant(s). ▪ Business travel is limited to 45 (forty-five) days and R500 000 cover for travelling to the USA for a family i.e. Member and Dependant(s). All other countries are covered up to 45 (forty-five) days for R3 million for a family i.e. Member and Dependant(s). - A Member must give at least 48 (forty-eight) hours in advance when he and/or his Dependant(s) are traveling overseas. Failure to notify to do so will result in claims being rejected.	

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	- General exclusions to services apply. Elective planned procedures undergone outside of South Africa are not covered.	
3.2.26 Day procedures at a day hospital facility	Day procedures at a day hospital facility for PMB conditions. Day procedures for non-PMBs in a network day hospital shall be funded at 100% of Scheme tariff/cost* limited to R50 000 per family per financial year, for the following non-PMB procedures: - Circumcision - Colonoscopy - Gastroscopy - Myringotomy and grommet insertion - Sterilisation (male and female) - Tonsillectomy Benefits shall be subject to: - Pre-authorisation; - Protocols and funding guidelines; and - DSPs for PMBs	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, a co-payment of R2 500 per event shall apply for the voluntary use of a private hospital.

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	Where procedures are done in a private hospital a co-payment of R2 500 per event shall apply for the voluntary use of a non-network hospital.	
3.2.27 Co-payments	A co-payment of R13 078 shall apply on the Rhythm1 and Rhythm2 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	RHYTHM1	RHYTHM2
- 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.		
3.3.1 Chronic medicine not listed on the chronic disease list ("non-CDL medicine")	No benefit	
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 70% of Scheme tariff with a 30% co-payment. Benefits are subject to prior application and approval by the Scheme.	
3.3.3 Biological medicine out of hospital: Biological medicine is a substance that is made from a living organism or its products and is used in the prevention, diagnosis, or treatment of acute and chronic diseases.	Scheme pre-approval is required and out-of-hospital benefits are limited to the treatment of certain PMB conditions, as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations, shall be paid at cost.	
3.3.4 Other high-cost medicine out of hospital	Scheme pre-approval is required and out-of-hospital benefits are limited to the treatment of certain PMB conditions, as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations, shall be paid at cost.	

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
3.3.5 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.	
3.3.6 Over-the-counter (OTC) medicine	No benefit.	Benefits shall be at 100% of Scheme tariff up to the limit of R634 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	RHYTHM1	RHYTHM2
3.4.5 Baby growth and development assessments	Children from 0 (zero) up to 2 (two) years of age: - 3 (three) assessments per year. - Assessments must be conducted at a pharmacy clinic or by a registered nurse.	
3.4.6 Female contraceptives	Applicable to all females of childbearing age: - Quantity and frequency depending on product up to the maximum of R2 550 per beneficiary per financial year, which includes all items classified in category of female contraceptives. - Intrauterine device (IUD) once every 5 (five) years.	
3.4.7 Mammogram	No benefit.	- Females 40 (forty) years and older - once every 24 (twenty-four) months. - Only for tariff code 34100; and - Must be referred by a Rhythm Network GP or a specialist that is part of the Rhythm Specialist Network.
3.4.8 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.	
3.4.9 Human Papilloma Virus (HPV) vaccinations	No benefit.	Females 9 (nine) – 26 (twenty-six) years of age: - 3 (three) vaccinations per beneficiary.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
		- Cervarix/Gardasil shall be funded at Mediscor Reference Price (MRP).
3.4.10 Prostate Specific Antigen (PSA) test: Tariff codes claimed by pathologists or nappi codes claimed by pharmacies in respect of this benefit are included.	No benefit.	Males 50 (fifty) years and older: - Once every 24 (twenty-four) months per beneficiary. - To be done at urologist or GP. Urologist/GP consultation paid from the consultation benefit.
3.4.11 PAP smear: Tariff codes claimed by pathologists or nappi codes claimed by pharmacies in respect of this benefit are included.	No benefit.	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 GP. - Consultation fee paid from the consultation benefit, subject to PMBs. Benefits in respect of PMBs for shall be paid from the applicable Scheme benefits.
3.4.12 Tempo programme: Benefits on the Tempo programme can only be accessed when a beneficiary undergoes a health risk assessment.	**1. Health assessments** Beneficiaries 16 (sixteen) years and older - 1 (one) per beneficiary per financial year for beneficiaries 16 (sixteen) years and older. - Biometric screening and lifestyle questionnaire must be completed at Wellness Network pharmacies, onsite at selected Employer Groups or at a Tempo biokineticist or DSP GPs. Only certain selected Employer Groups and primary nursing staff will be allowed to conduct	

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	the assessment. - Beneficiaries must complete a health assessment in order to unlock the rest of the Tempo programme benefits. **2. Fitness and nutritional interventions available to beneficiaries 16 (sixteen) years and older** Fitness - 1 (one) fitness test at a Tempo biokineticist conducted in person; and - 1 (one) follow-up in person or virtual consultation at a Tempo biokineticist to obtain a personalised fitness/exercise plan. Nutrition - 1 (one) nutritional assessment at a Tempo dietician; and - 1 (one) follow-up in person or virtual consultation at a Tempo dietician to obtain a personalised diet plan. **3. Emotional wellbeing journey** - 2 (two) questionnaires to be completed to assess whether the participant experiences symptoms of depression and/or anxiety, may only be accessed by the Member, adult dependant (i.e., spouse or partner), and other beneficiaries 21 (twenty-one) years and older. - Educational information, challenges, recordings, videos and support group details, may be accessed by all beneficiaries 16 (sixteen) years and older.	

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
3.4.13 Maternity benefits	Benefits shall be at 100% of Scheme tariff at Network Providers only for the following: Consultations: - 6 (six) antenatal consultations 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.	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 R127 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. Services rendered by Preferred Provider Negotiators (PPN) network optometrists shall be	

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	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.	
	Benefits from a PPN network optometrist shall be as follows: - Consultations: 1 (one) per beneficiary at 100% of cost - No benefits for spectacle frames or lens or contact lenses Benefits from a non-network provider shall be as follows: - Consultations: 1 (one) per beneficiary limited to R365 - No benefits for spectacle frames or lens or contact lenses	Benefits from a PPN network optometrist shall be as follows: - Consultations at a network provider: 1 (one) per beneficiary at 100% of cost - Spectacle frames at R245 (Member frame refund value after network discount R184) AND - Standard lenses: Single-vision lenses limited to R215 OR Bifocal lenses limited to R460 OR Multifocal lenses limited to R460 - In lieu of glasses Members can opt for contact lenses, limited to R700
3.6 OUT-OF-HOSPITAL BENEFITS	- No Personal Medical Savings Account. - Full cross subsidisation between Members shall apply without an annual limit.	

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	- 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 Rhythm Network. Members may only visit service providers registered on the Rhythm Network.	
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 Rhythm Network for the following: - Unlimited medically necessary consultations for basic primary care. Pre-approval is required after the 10th (tenth) visit.	Benefits shall be at 100% of Scheme tariff/cost* for consultations, visits and treatments by GPs registered on the Rhythm Network for the following: - Unlimited medically necessary consultations for basic primary care; and - Specified minor trauma treatment, including stitches, excision and repair, drainage of abscess and limb cast.
3.6.2 Pharmacy clinic nurse consultations	Benefits shall be at 100% of Scheme tariff/cost* for unlimited primary care nurse consultations (nappi code 981078001) at network pharmacies.	No benefit.
3.6.3 Diabetes primary care consultation	Benefits shall be at 100% of Scheme tariff subject to: - Registration with HaloCare; and - 2 (two) primary care consultations at Dis-Chem Pharmacies per financial year.	

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
3.6.4 Out-of-network or casualty visits	No benefit, except in respect of PMB conditions.	Every family qualifies for out-of-network GP and casualty visits: - Benefits shall be at 100% of Scheme tariff/cost* limited to R1 569 per family per year. - All radiology and pathology investigations at the casualty unit, that fall within the primary care radiology and pathology benefit schedule, as well as medicine costs 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. - The Member shall pay for the visit first and then claim back from the Scheme.
3.6.5 Specialist visits	Benefits shall only be considered if referred by a Rhythm Network GP or a specialist registered on the Rhythm Specialist Network or a PPN provider to a specialist on the Rhythm Specialist Network and shall be subject to the following:	Benefits shall only be considered if referred by a Rhythm Network GP or a specialist registered on the Rhythm Specialist Network or a PPN provider to a specialist on the Rhythm Specialist Network and shall be subject to the following: - Pre-approval by the Scheme;

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	- 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); and - Limited to R2 325 per family per financial year.	- The Scheme treatment protocol and clinical funding guidelines (which includes minor procedures done in specialist rooms and all consumable used); and - Benefits shall be at 100% of Scheme tariff limited to the following maxima per financial year: M = R1 586 and M1+= R2 643
3.6.6 Basic and specialised dentistry	Benefits shall be at 100% of Scheme tariff per financial year when clinically appropriate, subject to a designated service provider, the Rhythm Dental Network approved tariff list and conditions, as well as the following provisions: - 1 (one) consultation for full mouth examination per beneficiary per financial year, subject to the Scheme's list of dental codes;	Benefits shall be at 100% of Scheme tariff when clinically appropriate, subject to a designated service provider, the Rhythm 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;

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	- Preventative treatment once per beneficiary per financial year including scaling, polishing treatment and fillings as per protocol; - Primary extractions if clinically necessary; - No benefits shall apply for dentures; and - No benefits shall apply for specialised dentistry.	- 1 (one) set of dentures per family per 24 (twenty-four) months. Benefits shall be subject to the use of accredited dental laboratories; and - No benefits shall apply for specialised dentistry.
3.6.7 Medical aids, apparatus and appliances, including wheelchairs and hearing aids.	No benefit, except in respect of PMB conditions.	
3.6.8 Supplementary services Benefits include services rendered by physiotherapists, masseurs, chiropractors, osteopaths, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech therapists, biokinetics, private nursing (stoma therapy nursing, obtaining of	No benefit, except in respect of PMB conditions.	

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
specimen, observations and administration of medication, immunisations and IV's), psychiatric treatment, psychologists, social workers, homeopaths and acupuncture.		
3.6.9 Wound care benefit Includes dressings and negative pressure wound therapy (NPWT) treatment and nursing services out of hospital.	No benefit, except in respect of PMB conditions.	
3.6.10 Basic radiology and pathology	Standard diagnostic imaging and pathology services requested by a Rhythm 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.	
3.6.11 Specialised Diagnostic Imaging MRI and CT scans, magnetic resonance cholangiopancreatography (MRCP), whole body radioisotope. PET scans excluded.	No benefit, except in respect of PMB conditions.	
3.6.12 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 subject to the following: - Pre-authorisation; - Preferred providers or DSPs;	

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	- 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.	