ANNEXURE B.1 – BENEFIT OPTIONS
2026 BEAT RANGE

1.1 GENERAL CONDITIONS OF THE BENEFIT OPTIONS

1.1.1 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.

1.1.2 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.

1.1.3 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.

1.1.4 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.

1.1.5 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.

1.1.6 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.

1.1.7 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.

1.1.8 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):

1.1.8.1 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.

1.1.8.2 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:

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

1.1.8.2.2 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	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4

1.2 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.
- Benefits in respect of MRI scans, computer tomographic (CT) studies, or other specialised diagnostic imaging require that a benefit confirmation and reference number to be obtained from the Scheme's Contact Centre in advance or, in an emergency, on the 1st (first) working day after admission to a hospital.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
- 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 a specified amount indicated in Rule 1.2.28 shall be incurred per event if a day procedure is done in an acute hospital that is not a day hospital. If a DSP is used and the DSP does not work in a day hospital, the procedure shall be paid in full if it is done in an acute hospital, if it is arranged with the Scheme before the time. ▪ A co-payment of a specified amount indicated in Rule 1.2.29 shall apply on the Beat Network 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.					
1.2.1 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*. DSP Network applies.				
1.2.2 Take-home medicine:	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		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		Medicine prescribed by the treating provider for a patient discharged

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
Medicine supplied by the hospital when a patient is discharged.	Scheme tariff/cost* for a maximum supply of 7 (seven) days provided that: - the medicine is claimed as part of the hospital account; or - the medicine claim shall be limited to R450 if claimed from a retail pharmacy on the date of discharge. No benefit shall be awarded if medicine is not claimed within 3 (three) days from the date of discharge from hospital.		Scheme tariff/cost* for a maximum supply of 7 (seven) days provided that: - the medicine is claimed as part of the hospital account; or - the medicine claim shall be limited to R500 if claimed from a retail pharmacy on the date of discharge. No benefit shall be awarded if medicine is not claimed within 3 (three) days from the date of discharge from hospital.		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 provided that: - the medicine is claimed as part of the hospital account; or - the medicine claim shall be limited to R550 if claimed from a retail pharmacy on the date of discharge. No benefit shall be awarded if medicine is

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					not claimed within 3 (three) days from the date of discharge from hospital.
1.2.3 Biological medicine during hospitalisation Biological medicine is a substance that is made from a living organism or its products and is used in the prevention, diagnosis, or treatment of acute and chronic diseases.	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and limited to R12 144 per family per financial year.	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and limited to R18 215 per family per financial year.	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and limited to R24 286 per family per financial year.		Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and limited to R30 357 per family per financial year.
1.2.4 Treatment in mental health facilities	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 in hospital including inpatient electro-convulsive therapy and inpatient psychotherapy, OR 15 (fifteen) contact sessions for out-patient psychotherapy per beneficiary per financial year, Pre-authorisation and DSP Network.				

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.2.5 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 management per beneficiary per financial year.				
1.2.6 Consultations and procedures: Consultations, visits, operations, surgical procedures and anaesthetics during hospitalisation and/or admission to day clinics.	Claims submitted by General Practitioners (GPs) and specialists for treatment during hospitalisation shall be at 100% of Scheme tariff/cost*. DSP Network applies for the Beat Network and Beat3 Plus benefit options.				
1.2.7 Organ transplants (in and/or out of hospital): Pre-authorisation must be obtained.	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules, and shall be paid at cost as per PMB regulations.				

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.2.8 Stem cell transplants (in and/or out of hospital): Pre-authorisation must be obtained.	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules, and shall be paid at cost as per PMB regulations. The donor search and related costs shall be limited to the Scheme approved amount per financial year.				
1.2.9 Blood transfusion	Blood, operators' fees, transport charges and apparatus payable at 100% Scheme tariff/cost*.				
1.2.10 Dental / Oral / Maxillo-facial surgery	- Pre-authorisation must be obtained for all dental and/or maxilla-facial surgical procedure that need to be performed in theatre or in doctor's rooms 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.				
1.2.10.1 Dental and oral surgery (in and/or out of hospital)	No benefits for basic dental treatment or dental surgical procedures, except for the treatment of certain PMB conditions at the standard of care in the State sector, which shall be paid at cost at DSP day hospitals.	Qualifying PMB dental surgical procedures only at DSP day hospitals. Pulp procedures, extractions and restorations (fillings) in DSP day hospital, will be covered for beneficiaries aged 0 (zero) until 7 (seven) years and	100% at Scheme tariff limited to R10 217 per family per financial year for the following procedures performed either in or out of hospital: - Surgical extractions of teeth / roots / impactions / failed implants; - Surgical drainage of dental abscess; - Alveolectomy / alveolotomy (preparatory surgery for dental prosthesis); - Root canal related surgery.	100% at Scheme tariff limited to R12 772 per family per financial year for the following procedures performed either in or out of hospital: - Surgical extractions of teeth / roots /	

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
		disabled beneficiaries, shall be limited to R6 642 per family. Dental surgical procedures for beneficiaries over the age of 7 (seven) years shall be paid from the PMSA at 100% Scheme tariff for the following procedures performed in the doctor's rooms only: - Surgical extractions of teeth / roots / impactions; - Surgical drainage of abscess; - Apicectomy.			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	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.2.10.2 Major maxillo-facial surgery, strictly related to certain conditions	No benefits for maxillo-facial treatment or surgery, except for the treatment of PMB conditions as per standard of care in the State sector which shall be paid at cost at DSP day hospitals.		100% of Scheme tariff limited to R16 378 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 (arthrocentesis and arthroplasty); - Salivary gland surgery (removal of gland or salivary stone); - Life threatening sepsis (Ludwig's angina); and - Confirmed oral cancer.		100% of Scheme tariff limited to R16 678 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);

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					- Internal TM joint surgery (arthrocentesis and arthroplasty); - Salivary gland surgery (removal of gland or salivary stone); - Life threatening sepsis (Ludwig's angina); and - Confirmed oral cancer.
1.2.11 Prosthesis benefits	Benefits shall subject to the following: - Pre-authorisation; - Preferred providers or DSPs; - The treatment of certain PMB conditions, as per the standard of care in the State sector shall be paid at cost, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations; and - Services for non-PMB conditions shall be based on Scheme tariff or contracted fee and shall be subject to exclusions for joint replacement surgery.				

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.2.11.1 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 paid at 100% of Scheme tariff/cost* limited to the overall limit of R99 764 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular shall be limited to R57 441 - Pacemaker (single and dual chambers) shall be limited to R54 390 and at DSP prices - Endovascular and catheter-based procedures are subject to the Vascular prosthesis sub-limit and at DSP prices - Spinal including artificial disk (single level based) shall be limited to R39 819 - Drug-eluting stents are subject to the Vascular prosthesis sub-limit and at DSP prices - Mesh shall be limited to R13 975 - Gynaecology / Urology shall be limited to R11 419 - Lens implants shall be limited to R8 713 a lens per eye - Functional prosthesis (items used to replace or		Benefits shall be paid at 100% of Scheme tariff/cost* limited to the overall limit of R100 818 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular shall be limited to R68 929 - Pacemaker (single and dual chambers) shall be limited to R54 390 and at DSP prices - Endovascular and catheter-based procedures are subject to the Vascular prosthesis sub-limit and at DSP prices - Spinal including artificial disk (single level based) shall be limited to R39 966 - Drug-eluting stents are subject to the Vascular prosthesis sub-limit and at DSP prices - Mesh shall be limited to R14 047 - Gynaecology / Urology shall be limited to R11 601 - Lens implants R8 713 shall be limited to a lens per eye		Benefits shall be paid at 100% of Scheme tariff/cost* limited to the overall limit of R123 064 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular shall be limited to R74 674 - Pacemaker (single and dual chambers) shall be limited to R71 218 and at DSP prices - Endovascular and catheter-based procedures are subject to the Vascular

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
	augment an impaired bodily function) shall be limited to R35 613		- Functional prosthesis (items used to replace or augment an impaired bodily function) shall be limited to R36 763		prosthesis sub-limit and at DSP prices - Spinal including artificial disk (single level based) shall be limited to R42 522 - Drug-eluting stents shall be limited to R23 890 and at DSP prices - Mesh shall be limited to R15 777 - Gynaecology / Urology shall be limited to R11 570 - Lens implants shall be limited to R9 014 a lens per eye - Functional prosthesis (items used to replace or augment an impaired

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					bodily function) shall be limited to R39 060
1.2.11.2 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 can be requested from the Scheme.	No benefit, except in respect of PMB conditions.				Limited to R29 599 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) 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

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					public hospital practice. - Repair work to artificial limbs will be funded from the Medical aids, apparatus and appliances benefit indicated in Rule 1.7.3.
1.2.11.3 Exclusions on joint replacement surgery for non-PMB conditions	No benefit for joint replacement surgery, except for PMBs, subject to the following prosthesis limits, that form part of the Prosthesis – Internal overall limit, at 100% contracted fees: - Hip replacement and other major joints R41 918 - Knee and shoulder replacements R51 686 - Other minor joints R16 078		No benefit for joint replacement surgery, except for PMBs, subject to the following prosthesis limits, that form part of the Prosthesis – Internal overall limit, at 100% contracted fees: - Hip replacement and other major joints R42 221 - Knee and shoulder replacements R52 241 - Other minor joints R16 078		No benefit for joint replacement surgery, except for PMBs, subject to the following prosthesis limits, that form part of the Prosthesis – Internal overall limit, at 100% contracted fees: - Hip replacement and other major joints

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					R43 723 - Knee and shoulder replacements R58 086 - Other minor joints R17 848
1.2.12 Breast surgery for cancer	Treatment of the unaffected (non-cancerous) breast shall be limited to PMB provisions and is subject to Pre-authorisation and funding guidelines.				
1.2.13 Orthopaedic and medical appliances during hospitalisation: Appliances directly related to the hospital admission and/or procedure.	Benefits shall be at 100% of Scheme tariff/cost* limited to R15 690 per family per financial year for medically necessary appliances for back, leg, arm and neck support, crutches, surgical footwear and elastic stockings directly related to the admission and provided before discharge from hospital.				
1.2.14 Pathology during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*.				
1.2.15 Basic radiology during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost.				

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.2.16 Specialised diagnostic imaging and nuclear medicine (in and/or out of hospital): MRI scans, CT scans and nuclear/isotope studies. PET scans are only included as indicated per the benefit option. A benefit confirmation and reference number must be obtained from the Scheme's Contact Centre in advance.	Benefits shall be at 100% of Scheme tariff/cost* limited to a combined in and out of hospital benefit of R20 920 per family per financial year. PET scans are excluded, except for a PMB condition.	Benefits shall be at 100% of Scheme tariff/cost* limited to a combined in and out of hospital benefit of R23 012 per family per financial year. PET scans are excluded, except for a PMB condition.	Benefits shall be at 100% of Scheme tariff/cost* limited to a combined in and out of hospital benefit of R33 472 per family per financial year. PET scans are excluded, except for a PMB condition.	Benefits shall be at 100% of Scheme tariff/cost* limited to a combined in and out of hospital benefit of R36 610 per family per financial year. PET scans are excluded, except for a PMB condition.	Benefits shall be at 100% of Scheme tariff/cost* limited to a combined in and out of hospital benefit of R41 840 per family per financial year. PET scans are not subject to the abovementioned benefit limit and shall be limited to 1 (one) scan per beneficiary per financial year.
1.2.17 Oncology benefits (in or out of hospital)	Oncology programme benefits at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.				
1.2.18 Peritoneal dialysis and	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.				

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
haemodialysis (in or out of hospital)					
1.2.19 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.				
1.2.20 Confinements (birthing, including midwife-assisted births)	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.				
1.2.21 Refractive surgery and other procedures (in and/or out of hospital) done to improve or stabilise	No benefit, except in respect of PMB conditions.		Benefits shall be at 100% of Scheme tariff limited to R10 518 per eye, subject to Pre-authorisation and protocols.		Benefits shall be at 100% of Scheme tariff limited to R11 871 per eye, subject to Pre-authorisation and protocols.

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
vision, except for cataracts					
1.2.22 Cochlear implants and Bone Adhering Hearing Devices (BAHD) / Bone Adhering Hearing Aids (BAHA) implantation Including fees for all providers (e.g. the surgeon and anaesthetist), hospital and device.	No benefit, except in respect of PMB conditions.				Benefits shall be at 100% of Scheme tariff up to a maximum amount of R250 000 per beneficiary per financial year, and subject to Pre-authorisation and designated or preferred service providers. Sound processor upgrades once every 5 (five) years per beneficiary.
1.2.23 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, 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 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.2.24 Alternatives to hospitalisation (i.e. procedures done in the doctor's rooms)	Benefits shall be at 100% of Scheme tariff subject to: - Pre-authorisation; - Step-down facilities approved by the Scheme; and - Services must be rendered by registered private nurses and hospices.				
1.2.25 Advance illness benefit	Benefits shall be at 100% of Scheme tariff/cost* limited to R72 858 per beneficiary per financial year, subject to Pre-authorisation.				Benefits shall be at 100% of Scheme tariff/cost* limited to R109 288 per beneficiary per financial year, subject to Pre-authorisation.
1.2.26 Ambulance and emergency evacuation services	Benefits shall be subject to: - Provisions of benefits by Netcare 911, as the Scheme's capitated preferred provider for ambulance services. - Benefits shall only be payable if the evacuation service was involuntarily requested and delivered by a service provider other than the preferred provider: Provided that services in respect of PMB conditions shall be payable at cost, without deductibles or the use of co-payments, subject to the provisions of Rule 15.10 of the main rules read in conjunction with Annexure D.1 of these Rules, as shall be evaluated by the Scheme.				

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.2.27 International emergency medical cover	In addition to the provisions for foreign claims referred to in Rule 16.12 of the registered Bestmed Rules, the Member and his Dependant(s) qualify for additional benefits which shall be at 100% contracted tariff subject to the following: - Provision of benefits by Europ Assistance SA, as the Scheme's preferred provider for international travel insurance. - Cover for leisure and business travel for emergency medical and related expenses: ▪ Leisure travel is limited to 90 (ninety) days and R1 million 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 R5 million for a family i.e. Member and Dependant(s). ▪ Business travel is limited to 60 (sixty) days and R1 million cover for travelling to the USA for a family i.e. Member and Dependant(s). All other countries are covered up to 60 (sixty) days for R5 million for a family i.e. Member and Dependant(s). - A Member must give at least 48 (forty-eight) hours advance notice when he and/or his Dependant(s) are travelling 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.				
1.2.28 Day procedures at a day hospital facility	Day procedures at a day hospital or day clinic facility shall be funded at 100% of Scheme tariff/cost*, subject to: - Pre-authorisation; - Protocols and funding guidelines; and - DSPs and preferred providers				

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
	A co-payment of R2 872 shall be incurred per event if a day procedure is done in an acute hospital that is not a day hospital. If a DSP is used and the DSP does not work in a day hospital, the co-payment shall not apply if it is done in an acute hospital, if it is arranged with the Scheme before the time.				
1.2.29 Co-payments	**Voluntary use of a non-designated Hospital Network co-payment:** A co-payment of R15 025 shall apply on the Beat1 Network, Beat2 Network and Beat3 Network 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.			Not Applicable	

1.3 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.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
- 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 shall apply for the conditions indicated with double asterisks (**) where provision is not made in the Diagnosis and Treatment Pairs constituting the PMB package as listed in the Medical Schemes Act. - Approved PMB, CDL and non-CDL chronic medicine costs shall be paid from the non-CDL limit first. Thereafter, only approved PMB and CDL chronic medicine costs shall be paid by the Scheme. Approved treatment for organ transplant, chronic renal failure, multiple sclerosis and haemophilia will be paid directly from Scheme risk and not non-CDL limit. - Over-the-counter (OTC) medicine benefits are not applicable to the Beat1 and Beat1 Network benefit options.					
1.3.1 Chronic medicine not listed on the chronic disease list ("non-CDL medicine")	No benefit		Medicine on the formulary shall be covered at 80% of Scheme tariff with a 20% co-payment and non-formulary medicine shall be covered at 70% of Scheme tariff with a 30% co-payment. Payment shall be at Scheme tariff limited to M = R4 358 and M1+ = R8 865 per financial year, for the following 5 (five) non-CDL conditions: - Acne - severe - Allergic rhinitis		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. Payment shall be limited to

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
			- Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Eczema - severe - Migraine Prophylaxis Subject to: Prior application and approval by the Scheme and benefits shall be from the date on which the application was received by the Scheme or its proxy.		M = R9 571 and M1+ = R19 143 per financial year, for the following 9 (nine) non-CDL conditions: - Acne - severe - Allergic rhinitis - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Eczema - severe - Gastro Oesophageal Reflux Disease (GORD)** - Gout Prophylaxis** - Major Depression** shall be covered as a life-sustaining condition once the

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					non-CDL benefit limit has been depleted - Migraine prophylaxis - Obsessive Compulsive Disorder 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.
1.3.2 Medicine for PMB conditions including the conditions listed on the chronic disease list (CDL)	Benefits shall be at 100% of Scheme tariff/cost*, subject to: - Prior application and approval by the Scheme. - A co-payment of 30% shall apply for the voluntary use of non-formulary medicine.				Benefits shall be at 100% of Scheme tariff/cost*, subject to:

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					- Prior application and approval by the Scheme. - A co-payment of 20% shall apply for the voluntary use of non-formulary medicine.
1.3.3 Biologicals 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.				
1.3.4 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.				

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.3.5 Acute medicine	No benefit	Benefits shall be at 100% of Scheme tariff from the PMSA for: - Medicine, excluding medicine referred to in Annexure C2 of the registered Rules, prescribed out of a hospital by a medical practitioner, a contracted Pharmacist Primary Care Drug Therapy (PCDT) pharmacist, or dentist or a person authorised thereto by law. - Registered homeopathic remedies, injections and herbal remedies.			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: M = R3 652 and M1+ = R7 376 Benefits shall be for: - Medicine, excluding medicine referred to in Annexure C2 of the registered Rules, prescribed out of a hospital by a medical

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					practitioner, a contracted Pharmacist Primary Care Drug Therapy (PCDT) pharmacist, dentist or a person authorised thereto by law. - Registered homeopathic 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.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.3.6 Over-the-counter (OTC) medicine The member may choose how to access OTC medicine benefits: 1. The OTC medicine benefit with a set limit on the PMSA. OR 2. The OTC medicine benefit without a set limit on the PMSA to accumulate a self-payment gap.	No benefit	Shall be paid at 100% at Scheme tariff from the PMSA. Benefit includes, but not limited to, purchases of sunscreen, vitamins and minerals with Nappi codes on the Scheme's formulary.			1. The OTC medicine benefit up to the limit of R1 214 per family per financial year, paid at 100% of Scheme tariff from the PMSA. Benefit includes, but not limited to, purchases of sunscreen, vitamins and minerals with Nappi codes on the Scheme's formulary. 1.1 Once the set limit has been reached, the member may access further OTC medicine benefits through the Vested

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					Medical Savings Account where purchases shall be paid at 100% Scheme tariff. OR 2. OTC medicine benefit without a limit on the PMSA to accumulate a self-payment gap once the limit of R1 214. has been reached. 2.1 The threshold will be determined by the amount allocated to the annual PMSA at the

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					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. 2.2 Once a self-payment gap has accumulated, the day-to-day health care services, as indicated in Rule 1.7 of this Annexure, will

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					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

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					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

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					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

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					relevant health service was rendered.
1.4 PREVENTATIVE CARE AND WELLNESS BENEFITS	Benefits shall be at 100% of Scheme tariff and DSPs or preferred providers.				
1.4.1 Influenza vaccine	1 (one) vaccine per beneficiary per financial year.				
1.4.2 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.				
1.4.3 Travel vaccinations	No benefit	Bestmed provides cover for certain mandatory travel vaccines for typhoid, yellow fever, tetanus, meningitis, hepatitis and cholera from Scheme risk benefits.			
1.4.4 Baby growth and development assessments	Children from 0 (zero) up to 2 (two) years of age: - 3 (three) assessments per year. - Assessments must be conducted at a pharmacy clinic or by a registered nurse.				
1.4.5 Paediatric immunisations	No benefit	Paediatric vaccines according to the State recommended programme for babies and children.			

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.4.6 Female contraceptives	Applicable to all females of childbearing age: - Oral / injectable / implantable female contraceptives limited to R2 092 per beneficiary per financial year. OR - Intrauterine devices (IUD) - 1 (one) device once every 5 (five) years limited to R3 295.	Applicable to all females of childbearing age: - Oral / injectable / implantable female contraceptives limited to R2 301 per beneficiary per financial year. OR - Intrauterine devices (IUD) – 1 (one) device limited to R3 595. The insertion (i.e. consultation and procedure) of the device to be done by a gynaecologist or GP once every 5 (five) years.	Applicable to all females of childbearing age: - Oral / injectable / implantable female contraceptives limited to R2 510 per beneficiary per financial year. OR - Intrauterine devices (IUD) – 1 (one) device limited to R3 795. The insertion (i.e. consultation and procedure) of the device to be done by a gynaecologist or GP once every 5 (five) years.		Applicable to all females of childbearing age: - Oral / injectable / implantable female contraceptives limited to R2 801 per beneficiary per financial year. OR - Intrauterine devices (IUD) – 1 (one) device limited to R4 225. The insertion (i.e. consultation and procedure) of the device to be done by a gynaecologist or GP

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					once every 5 (five) years.
1.4.7 Preventative dentistry	No benefit	Benefits are applicable per beneficiary: 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, every 6 (six) months from the date of service. 5. **Fluoride treatment:** All ages, every 6 (six) months from the date of service. 6. **Fissure sealing:** Beneficiaries up to and including 21 (twenty-one) years, the frequency will be in accordance with accepted protocol. 7. **Space maintainers:** During primary and mixed denture stage, once per space.			
1.4.8 HIV rapid test	Voluntary Testing and Counselling (VCT) as preventive care, subject to Scheme protocols and funding guidelines.				

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.4.9 Mammogram	Females 40 (forty) years and older - once every 24 (twenty-four) months.				
1.4.10 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).				
1.4.11 Prostate Specific Antigen (PSA) test: Tariff codes claimed by pathologists or Nappi codes claimed by pharmacies in respect of this benefit are included.	Males 45 (forty-five) years and older: - Once every 24 (twenty-four) months per beneficiary. - To be done at a urologist or GP. Urologist or GP consultation paid from the available consultation benefit.				
1.4.12 Colon Cancer Screening Tariff codes claimed by pathologists in respect of this benefit are included.	Benefit is subject to: - 1 (one) Faecal Occult Blood Test (FOBT) per beneficiary aged 40 (forty) years or older every 24 (twenty-four) months. - To be done at a GP or specialist, the consultation shall be paid from the available consultation benefit.				
1.4.13 PAP smear:	Preventative benefit is subject to: - Females 18 (eighteen) years and older. - Once every 24 (twenty-four) months per beneficiary.				Preventative benefit is subject to:

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
Tariff codes claimed by pathologists in respect of this benefit are included.	- To be done at a gynaecologist or GP. - Consultation fee paid from the available PMSA on the Beat2, Beat2 Network, Beat3, Beat3 Network and Beat3 Plus benefit options. The Member shall be liable for the consultation costs on the Beat1 and Beat1 Network benefit options.				- Females 18 (eighteen) years and older. - Once every 24 (twenty-four) months per beneficiary for PAP smear tariff code 4566 or 4559. - To be done at a gynaecologist or GP. - Consultation fee paid from the Preventative Care benefit.
1.4.14 Tempo programme: Benefits on the Tempo wellness programme can only be accessed when a beneficiary undergoes a lifestyle screening.	**1. Tempo Lifestyle Screening** Beneficiaries 16 (sixteen) years and older - 1 (one) per beneficiary per financial year. - This includes a biometric screening and lifestyle questionnaire that must be completed at Network pharmacy clinics, or onsite at selected Employer groups, or at an accredited Tempo biokineticist, or Tempo GP. Only participating Employer groups which allow onsite screening and nurses onsite, or allow the Scheme to conduct the lifestyle screening at the workplace. Alternatively, Members can obtain the services from their pharmacy clinics or accredited Tempo biokineticist or nurses.				

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
	- Beneficiaries must complete a lifestyle screening in order to unlock the biokineticist and dietician consultations that form part 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.				
1.5 MATERNITY BENEFITS	Benefits shall be at 100% of Scheme tariff per beneficiary per event, subject to the following: Consultations: - 6 (six) antenatal consultations at either a GP/gynaecologist/midwife. Ultrasounds:		Benefits shall be at 100% of Scheme tariff per beneficiary per event, subject to 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.		

<table>
<tr><th>HEALTHCARE SERVICES</th><th>BEAT1 AND BEAT1 NETWORK</th><th>BEAT2 AND BEAT2 NETWORK</th><th>BEAT3 AND BEAT3 NETWORK</th><th>BEAT3 PLUS</th><th>BEAT4</th></tr>
<tr><td></td><td colspan="2">- 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.</td><td colspan="3">- 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 R145 per claim, once a month, for a maximum of 9 (nine) months.</td></tr>
<tr><td rowspan="2">1.6 OPTOMETRY BENEFITS</td><td rowspan="2">No benefit</td><td colspan="2" rowspan="2">Benefits shall be paid from the PMSA.</td><td colspan="2">Optometry benefits are available per beneficiary every 24 (twenty-four) months from the date of service.

Services rendered by the designated optical network, Preferred Provider Negotiators (PPN), optometrists shall be payable at 100% of contracted fee. Services rendered by a non-network provider shall be subject to the maxima indicated.</td></tr>
<tr><td>Benefits from a PPN optometrist shall be as follows:</td><td>Benefits from a PPN optometrist shall be as follows:</td></tr>
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HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
				- Consultations: 1 (one) per beneficiary at 100% of cost. - Spectacle frames or lens enhancements limited to R990 AND - Lenses: standard lenses (i.e. single vision or bifocal or multifocal lenses) at 100% of cost OR - Contact lenses limited to R1 760 Benefits from a non-network provider shall be as follows:	- Consultations: 1 (one) per beneficiary at 100% of cost. - Spectacle frames or lens enhancements limited to R1 270 AND - Lenses: standard lenses (i.e. single vision or bifocal or multifocal lenses) at 100% of cost OR - Contact lenses limited to R2 085 Benefits from a non-network provider shall be as follows:

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
				- Consultations: 1 (one) per beneficiary limited to R420 - Spectacle frames or lens enhancements limited to R743 AND - Lenses: Single-vision lenses limited to R225 OR Bifocal lenses limited to R485 OR Multifocal lenses limited to R1 080 (consisting of R850 per base lens plus R230 per branded lens add-on) OR	- Consultations: 1 (one) per beneficiary limited to R420 - Spectacle frames or lens enhancements limited to R953 AND - Lenses: Single-vision lenses limited to R225 OR Bifocal lenses limited to R485 OR Multifocal lenses limited to R1 080 (consisting of R850 per base lens plus R230 per branded lens add-on) OR

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
				- In lieu of glasses Members can opt for contact lenses, limited to R1 760	- In lieu of glasses Members can opt for contact lenses, limited to R2 085
1.7 OUT-OF-HOSPITAL BENEFITS	No Personal Medical Savings Account (PMSA). Full cross subsidisation between Members shall apply without an annual limit.	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.			- 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

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					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. - The following combined overall limit for day-to-day benefits shall apply per financial year: M = R16 227 and M1+= R32 452
1.7.1 GP, nurse and specialist consultations	No benefit	Benefits shall be at 100% of Scheme tariff from the PMSA.			Benefits shall be at 100% of Scheme tariff from the PMSA. Once

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
Consultations, visits, diagnostic examinations, injections and emergency unit visits (where a procedure room was used) with General Practitioners (GPs), contracted Nursing Clinical Services, contracted Pharmacist Primary Care Drug Therapy (PCDT) pharmacists, Specialists, Homeopaths and Herbalists.					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: M = R4 133 and M1+ = R7 361
1.7.2 Basic and specialised dentistry Includes basic and specialised dentistry not defined under Preventative dentistry	No benefit	Benefits shall be at 100% of Scheme tariff from the PMSA, subject to the following:	Benefits shall be at 100% of Scheme tariff from the PMSA, subject to the following: - Basic dentistry shall be paid from the Preventative dentistry benefit or the PMSA.		Benefits shall be at 100% of Scheme tariff from the PMSA, subject to the following: - Basic dentistry shall be paid from the

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
benefits or Dental / Oral / Jaw surgical benefits.		- Basic dentistry shall be paid from the Preventative dentistry benefit or the PMSA. - Specialised dentistry which includes the following shall be paid from the PMSA: - 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.	- Specialised dentistry which includes the following shall be paid from the PMSA: - 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 related to the aforementioned services.		Preventative dentistry or PMSA. - Specialised dentistry benefits which 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

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					- Dental implants, implant costs and all laboratory costs related to the aforementioned services. 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: M = R7 149 and M1+ = R14 359
1.7.3 Medical aids, apparatus and appliances including	No benefit	Benefits shall be at 100% of Scheme tariff from the PMSA, for the following: - Hearing aid - Pre-authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 1.7.3;			Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
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, custom) and the		- Back, leg, arm and neck support; - Wheelchairs; - Surgical footwear; - Crutches; - Elastic stockings; - Repair work on hearing aids, artificial limbs, wheelchairs, etc.; and - Stoma products, Oxygen and Diabetic supplies for non-PMB conditions.			have been depleted, benefits shall be subject to the overall day-to-day limit and R14 575 per family per financial year for appliances that shall include any of the items listed below: - Back, leg, arm and neck support; - Wheelchairs; - Surgical footwear; - Crutches; - Elastic stockings; - Repair work on artificial limbs, wheelchairs, etc.; and - Stoma products, Oxygen and Diabetic

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
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).					supplies for non-PMB conditions. Hearing aids and/or repair at 100% of Scheme tariff limited to R13 357 per family every 24 (twenty-four) months. Pre-authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 1.7.3.
1.7.4 Supplementary services Benefits include services rendered by physiotherapists, masseurs, chiropractors,	No benefit	Benefits shall be at 100% of Scheme tariff from the PMSA.		Benefits shall be at 100% of Scheme tariff and be limited to R2 188 per family per financial year subject to the use of DSPs.	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
osteopaths, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech therapists, biokinetics, private nursing (stoma therapy nursing, obtaining of specimen, observations and administration of medication, immunisations and IV's), psychiatric treatment, psychologists and social workers.				Once the set limit has been reached, the member may access further benefits from the PMSA at 100% Scheme tariff.	100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R6 311 and M1+ = R12 817
1.7.5 Wound care benefit Includes dressings and negative pressure	NPWT treatment shall be at 100% Scheme tariff, subject to Pre-authorisation. General wound care shall be at 100% of Scheme tariff and be limited to R4 463 per family per financial year.				General wound care shall be at 100% of Scheme tariff from the PMSA. Once the funds

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
wound therapy (NPWT) treatment and nursing services out of hospital.					in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R6 311 per family per financial year. NPWT treatment shall be at 100% Scheme tariff, subject to Pre-authorisation.
1.7.6 Basic radiology and pathology	No benefit	Benefits shall be at 100% of Scheme tariff from the PMSA.			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

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					following maxima per financial year: M = R4 132 and M1+ = R8 414
1.7.7 Back and Neck Programme	Benefits shall be payable at 100% of contracted fee and are applicable to all ages – subject to Pre-authorisation: - Applicable to beneficiaries with serious back or neck problems that may require surgery and use of this programme is in lieu of surgery. - Preferred providers, i.e. DBC or Workability clinics. - The Scheme may identify appropriate participants for evaluation at a DBC or Workability clinic. Based on the first assessment, a rehabilitation treatment plan is drawn up and initiated over an uninterrupted period that will be specified by the provider.				
1.7.8 Rehabilitation after trauma Benefits for rehabilitation shall be aimed at the recovery of impeded vital functions immediately	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.				Benefits shall be at 100% of Scheme tariff/cost*.

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
after trauma such as a stroke or heart attack.					