ANNEXURE B.2 – BENEFIT OPTIONS
2026 PACE RANGE

2.1 GENERAL CONDITIONS OF THE BENEFIT OPTIONS

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

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

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

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

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

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

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

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

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

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

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

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

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4

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

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

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
- Co-payments: ▪ A co-payment of a specified amount indicated in Rule 2.2.29 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.				
2.2.1 Hospitalisation: Pre-authorisation must be obtained for accommodation (hospital stay) in a general ward, intensive care and high-care unit, theatre, and material.	Benefits shall be at 100% of Scheme tariff/cost*.			
2.2.2 Take-home medicine: Medicine supplied by the hospital when a patient is discharged.	Medicine prescribed by the treating provider for a patient discharged from hospital, relating to the admission, to take home will be paid at 100% of Scheme tariff/cost* for a maximum supply of 7 (seven) days provided that: - the medicine is claimed as part of the hospital account; or	Medicine prescribed by the treating provider for a patient discharged from hospital, relating to the admission, to take home will be paid at 100% of Scheme tariff/cost* for a maximum supply of 7 (seven) days provided that: - the medicine is claimed as part of the hospital account; or - the medicine shall be limited to R600 if claimed from a retail pharmacy if claimed 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.	Medicine prescribed by the treating provider for a patient discharged from hospital, relating to the admission, to take home will be paid at 100% of Scheme tariff/cost* for a maximum supply of 7 (seven) days provided that: - the medicine is claimed as part of the hospital account; or	

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- the medicine shall be limited to R550 if claimed from a retail pharmacy if claimed 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.			- the medicine shall be limited to R700 if claimed from a retail pharmacy if claimed 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.
2.2.3 Biological medicine during hospitalisation Biological medicine is a substance that is made from a living organism or its products and is used in the prevention, diagnosis, or treatment of acute and chronic diseases.	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and limited to R36 430 per family per financial year.	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and the biological medicine benefit limit indicated on Rule 2.3.3.		

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.4 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.			
2.2.5 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.			
2.2.6 Consultations and procedures: Consultations, visits, operations, surgical procedures and anaesthetics for surgical procedures during hospitalisation.	Claims submitted by General Practitioners (GPs) and specialists for treatment during hospitalisation shall be paid at 100% of Scheme tariff/cost*.			
2.2.7 Organ transplants (in and/or out of hospital): Pre-authorisation must be obtained.	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules, and shall be paid at cost as per PMB regulations.			
2.2.8 Stem cell transplants (in and/or out of hospital):	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.			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
Pre-authorisation must be obtained.				
2.2.9 Blood transfusion	Blood, operators' fees, transport charges and apparatus payable at 100% of Scheme tariff/cost*.			
2.2.10 Dental / Oral / Maxillo-facial surgery	- Pre-authorisation must be obtained for any surgical procedure that needs to be performed in a theatre and shall be payable at 100% of Scheme tariff. - The treatment of certain PMB conditions, as per the standard of care in the State sector shall be paid at cost, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations.			
2.2.10.1 Dental and oral surgery (in and/or out of hospital):	Benefits shall be at 100% of 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;	Benefits shall be at 100% of Scheme tariff limited to R16 979 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;	Benefits shall be at 100% of Scheme tariff limited to R21 335 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;	Benefits shall be at 100% of Scheme tariff limited to R25 542 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;

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- 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.	- 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.	- 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.	- 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.
2.2.10.2 Major maxillo-facial surgery, strictly related to certain conditions	Benefits shall be at 100% of Scheme tariff limited to R16 527 per family per financial year, strictly for the following conditions: - Severe trauma (soft tissue injuries, fractures of jaws and facial bones);	Benefits shall be at 100% of Scheme tariff strictly for the following conditions: - Severe trauma (soft tissue injuries, fractures of jaws and facial bones); - Cleft lip and palate; - Crouson's disease; - Malunited craniomaxillary disjunction; - Post-traumatic defects (root residues in sinus, secondary oro-nasal fistula, faciostenosis); - Internal TM joint surgery (condylectomy, arthrocentesis, arthroplasty, total joint reconstruction);		

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- 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.	- Salivary gland surgery (removal of gland or salivary stone); - Life threatening sepsis (Ludwig's angina); and - Confirmed oral cancer.		
2.2.11 Prosthesis Benefits	Benefits shall subject to the following: - Pre-authorisation; - Preferred providers or DSPs; - The treatment of certain PMB conditions, as per the standard of care in the State sector shall be paid at cost, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations; and			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Services for non-PMB conditions shall be based on Scheme tariff or contracted fee and shall be subject to exclusions for joint replacement surgery.			
2.2.11.1 Prosthesis – Internal 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 R114 189 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R74 674; - Pacemaker (single and dual chambers) shall be limited to R71 068 and at DSP prices; - Endovascular and catheter-based procedures are subject to the Vascular	Benefits shall be paid at 100% of Scheme tariff/cost* limited to the overall limit of R146 642 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R74 674; - Pacemaker (single and dual chambers) shall be limited to R79 255 and at DSP prices; Endovascular and catheter base procedures are subject to the Vascular	Benefits shall be paid at 100% of Scheme tariff/cost* limited to the overall limit of R147 394 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R79 269; - Pacemaker (single and dual chambers) shall be limited to R79 255 and at DSP prices; - Endovascular and catheter base procedures are subject to the Vascular	Benefits shall be paid at 100% of Scheme tariff/cost* limited to the overall limit of R170 081 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R79 269; - Pacemaker (single and dual chambers) shall be limited to R79 255 and at DSP prices; - Endovascular and catheter base procedures are subject to the Vascular prosthesis sub-limit and at DSP prices;

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	prosthesis sub-limit and at DSP prices; - Spinal prosthesis including artificial disk (single level based) shall be limited to R41 618; - Drug-eluting stents are subject to the Vascular prosthesis sub-limit and at DSP prices; - Mesh shall be limited to R15 626; - Gynaecological/Urological prosthesis shall be limited to R11 269; - Lens implant shall be limited to R8 565 a lens per eye; - Functional prosthesis – items used to replace or augment an impaired	prosthesis sub-limit and at DSP prices; - Spinal prosthesis including artificial disk (single level based) shall be limited to R73 517; - Drug-eluting stents shall be limited to R24 040 and at DSP prices; - Mesh shall be limited to R24 040; - Gynaecological/Urological prosthesis shall be limited to R17 954; - Lens implant shall be limited to R15 416 a lens per eye; - Hip prosthesis and other major joints shall be limited to R66 033;	prosthesis sub-limit and at DSP prices; - Spinal prosthesis including artificial disk (single level based) shall be limited to R73 657; - Drug-eluting stents shall be limited to R24 040 and at DSP prices; - Mesh shall be limited to R24 040; - Gynaecological/Urological prosthesis shall be limited to R18 030; - Lens implant shall be limited to R15 416 a lens per eye; - Hip prosthesis and other major joints shall be limited to R66 108;	- Spinal prosthesis including artificial disk (single level based) shall be limited to R85 048; - Drug-eluting stents shall be limited to R28 323 and at DSP prices; - Mesh shall be limited to R24 942; - Gynaecological/Urological prosthesis shall be limited to R20 584; - Lens implant shall be limited to R22 792 a lens per eye; - Hip prosthesis and other major joints shall be limited to R76 102; - Knee and shoulder prosthesis shall be limited to R88 120;

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	bodily function - shall be limited to R39 060.	- Knee and shoulder prosthesis shall be limited to R76 627; - Other minor joints shall be limited to R28 471; and - Functional prosthesis – items used to replace or augment an impaired bodily function - shall be limited to R41 358.	- Knee and shoulder prosthesis shall be limited to R77 001; - Other Minor joints shall be limited to R28 471; and - Functional prosthesis – items used to replace or augment an impaired bodily function - shall be limited to R41 358.	- Other Minor joints shall be limited to R28 323; and - Functional prosthesis – items used to replace or augment an impaired bodily function - shall be limited to R45 953.
2.2.11.2 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 prostheses covered by the Scheme can be requested from the Scheme.	Benefits shall be at 100% of Scheme tariff limited to R28 998 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	Benefits shall be at 100% of Scheme tariff limited to R34 557 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	Benefits shall be at 100% of Scheme tariff limited to R34 708 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	Benefits shall be at 100% of Scheme tariff limited to R39 216 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

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	in terms of the amputated limbs will be assessed by the Scheme in line with what is considered predominant in the public hospital practice. - Repair work to artificial limbs will be funded from the Medical aids, apparatus and appliances benefit indicated in Rule 2.7.4.	in terms of the amputated limbs will be assessed by the Scheme in line with what is considered predominant in the public hospital practice. - Repair work to artificial limbs will be funded from the Medical aids, apparatus and appliances benefit indicated in Rule 2.7.4.	in terms of the amputated limbs will be assessed by the Scheme in line with what is considered predominant in the public hospital practice. - Repair work to artificial limbs will be funded from the Medical aids, apparatus and appliances benefit indicated in Rule 2.7.4.	of the amputated limbs will be assessed by the Scheme in line with what is considered predominant in the public hospital practice. - Repair work to artificial limbs will be funded from the Medical aids, apparatus and appliances benefit indicated in Rule 2.7.4.
2.2.11.3 Exclusions on joint replacement surgery for non-PMB conditions	No benefit for joint replacement surgery, except for PMBs, subject to the following prosthesis limits, which form part of the Prosthesis – Internal overall limit, at 100% contracted fees:	Not applicable		

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Hip prosthesis and other major joints shall be limited to R42 369; - Knee and shoulder prosthesis shall be limited to R56 344; and - Other minor joints shall be limited to R17 505.			
2.2.12 Medically necessary breast reduction surgery Including fees for all providers (e.g. the surgeon and anaesthetist) and hospital	No benefit		Benefits shall be at 100% of Scheme tariff up to a maximum amount of R100 000 per family per financial year, subject to Pre-authorisation and protocols.	
2.2.13 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.			
2.2.14 Pathology during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*.			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.15 Basic radiology during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*.			
2.2.16 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 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.	Benefits shall be at 100% of Scheme tariff/cost* limited to a combined in and out of hospital benefit of R43 932 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.		Benefits shall be at 100% of Scheme tariff/cost* limited to a combined in and out of hospital benefit of R47 070 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.
2.2.17 Oncology benefits (in or out of hospital)	Oncology Programme. Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.			
2.2.18 Breast surgery for cancer	Treatment of the unaffected (non-cancerous) breast shall be limited to PMB provisions and is subject to Pre-authorisation and funding guidelines.			
2.2.19 Peritoneal dialysis and haemodialysis (in or out of hospital)	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.20 HIV/AIDS benefits (in or out of hospital)	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.			
2.2.21 Confinements (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.			
2.2.22 Refractive surgery and other procedures (in and/or out of hospital) done to improve or stabilise vision, except for cataracts	Benefits shall be at 100% of Scheme tariff limited to R11 359 per eye, subject to Pre-authorisation and protocols.	Benefits shall be at 100% of Scheme tariff limited to R11 869 per eye, subject to Pre-authorisation and protocols.	Benefits shall be at 100% of Scheme tariff limited to R12 772 per eye, subject to Pre-authorisation and protocols.	
2.2.23 Cochlear implants and Bone Adhering Hearing Devices (BAHD) / Bone Adhering Hearing Aids (BAHA) implantation	Benefits shall be at 100% of Scheme tariff up to a maximum amount of R250 000 per beneficiary per financial year, and subject to	Benefits shall be at 100% of Scheme tariff up to a maximum amount of R285 000 per beneficiary per financial year, and subject to	Benefits shall be at 100% of Scheme tariff up to a maximum amount of R320 000 per beneficiary per financial year, and subject to Pre-	Benefits shall be at 100% of Scheme tariff up to a maximum amount of R350 000 per beneficiary per financial year, and subject to

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
Including fees for all providers (e.g. the surgeon and anaesthetist), hospital and device.	Pre-authorisation and designated or preferred service providers. Sound processor upgrades once every 5 (five) years per beneficiary.	Pre-authorisation and designated or preferred service providers. Sound processor upgrades once every 5 (five) years per beneficiary.	authorisation and designated or preferred service providers. Sound processor upgrades once every 5 (five) years per beneficiary.	Pre-authorisation and designated or preferred service providers. Sound processor upgrades once every 5 (five) years per beneficiary.
2.2.24 Supplementary services during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*, provided that the services are related to the hospital admission of the patient and are in line with the Scheme funding guidelines and protocols, for supplementary services which include services rendered by physiotherapists, masseurs, chiropractors, osteopaths, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech therapists, biokinetics, stoma therapist and social workers.			
2.2.25 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.			
2.2.26 Advance illness benefit	Benefits shall be at 100% of Scheme tariff/cost* limited to R91 073 per beneficiary per financial year, subject to Pre-authorisation and treatment plan.	Benefits shall be at 100% of Scheme tariff/cost* limited to R145 716 per beneficiary per financial year, subject to Pre-authorisation and treatment plan.		

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.27 Ambulance and emergency evacuation services	Benefits shall be subject to: - Provision of benefits by Netcare 911, as the Scheme's capitated preferred provider for ambulance services. - Benefits shall only be payable if the evacuation service was involuntarily requested and delivered by a service provider other than the preferred provider: Provided that services in respect of PMB conditions shall be payable at cost, without deductibles or the use of co-payments, subject to the provisions of Rule 15.10 of the main rules read in conjunction with Annexure D.1 of these Rules, as shall be evaluated by the Scheme.			
2.2.28 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 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 in advance when he and/or his Dependant(s) are travelling overseas. Failure to do so will result in claims being rejected.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- General exclusions to services apply. Elective planned procedures undergone outside of South Africa are not covered.			
2.2.29 Day procedures at a day hospital facility	Day procedures at a day hospital or day clinic facility shall be funded at 100% of Scheme tariff/cost*, subject to: - Pre-authorisation; - Protocols and funding guidelines; and - DSPs and preferred providers A co-payment of R2 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.			
2.3. MEDICINE BENEFITS Benefits for chronic, high-cost medicine, acute and over-the-counter (OTC) medicine shall be subject to: - Prior application and approval by the Scheme where indicated. - 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.				

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
- Each prescription or repeat prescription shall be limited to one month's supply per beneficiary. The Scheme may, at its sole discretion and according to the relevant protocols, grant an advance supply of medicine upon receipt of the relevant application. - Non-CDL medicine benefits will apply for the conditions indicated with double asterisks (**) where provision is not made in the Diagnosis and Treatment Pairs constituting the PMB package as listed in the Medical Schemes Act. - Approved PMB, CDL and non-CDL chronic medicine costs shall be paid from the non-CDL limit first. Thereafter, only approved PMB and CDL chronic medicine costs shall be paid by the Scheme. Approved treatment for organ transplant, chronic renal failure, multiple sclerosis and haemophilia will be paid directly from Scheme risk and not non-CDL limit. - Approved PMB biological and non-PMB biological medicine costs shall be paid from the applicable biological medicine limit first. Thereafter, only approved PMB biological medicine costs shall be paid by the Scheme.				
2.3.1 Chronic medicine not listed on the chronic disease list ("non-CDL medicine")	Medicine on the formulary shall be covered at 90% of Scheme tariff with a 10% co-payment and non-formulary medicine shall be covered at 75% of Scheme tariff with a 25% co-payment. Payment shall be at Scheme tariff limited to M = R8 414 and M1+ = R16 827 for the	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 at Scheme tariff limited to M = R11 488 and M1+ = R22 976 for the	Medicine on the formulary shall be covered at 90% of Scheme tariff with a 10% co-payment and non-formulary medicine shall be covered at 85% of Scheme tariff with a 15% co-payment. Payment shall be at Scheme tariff limited to M = R17 654 and M1+ = R35 310 for the	Medicine on the formulary shall be covered at 100% of Scheme tariff and non-formulary medicine shall be covered at 90% of Scheme tariff with a 10% co-payment. Payment shall be at Scheme tariff limited to M = R25 165 and M1+ = R50 558 for the following 29 (twenty-nine) non-CDL conditions:

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	following 7 (seven) non-CDL conditions: - Acne - severe - Allergic rhinitis - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Eczema - severe - Gout Prophylaxis** - Major Depression** shall be covered as a life-sustaining condition once the non-CDL benefit limit has been depleted - Migraine prophylaxis Subject to:	following 20 (twenty) non-CDL conditions: - Acne - severe - Allergic rhinitis - Ankylosing Spondylitis - Alzheimer's disease - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Autism - Collagen diseases - Dermatomyositis - Eczema - severe - Gastro Oesophageal Reflux Disease (GORD)** - Gout Prophylaxis** - Major Depression** shall be covered as a	following 20 (twenty) non-CDL conditions: - Acne - severe - Allergic rhinitis - Ankylosing Spondylitis - Alzheimer's disease - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Autism - Collagen diseases - Dermatomyositis - Eczema - severe - Gastro Oesophageal Reflux Disease (GORD)** - Gout Prophylaxis** - Major Depression** shall be covered as a life-	- Acne - severe - Allergic rhinitis - Ankylosing Spondylitis - Alzheimer's disease - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Autism - Blepharospasm - Collagen diseases - Dermatomyositis - Dystonia** - for ongoing or long-term chronic use - Eczema - severe - Gastro Oesophageal Reflux Disease (GORD)** - Gout Prophylaxis** - Hypopituitarism - Major Depression** shall be covered as a life-

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Prior application and approval by the Scheme and benefits shall be from the date on which the application was received by the Scheme or its proxy.	life-sustaining condition once the non-CDL benefit limit has been depleted - Migraine prophylaxis - Neuropathy - Obsessive Compulsive Disorder - Osteoarthritis - Osteoporosis** - Paget's disease - Psoriasis - Urinary incontinence Subject to: - 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.	sustaining condition once the non-CDL benefit limit has been depleted - Migraine prophylaxis - Neuropathy - Obsessive Compulsive Disorder - Osteoarthritis - Osteoporosis** - Paget's disease - Psoriasis - Urinary incontinence Subject to: - 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.	sustaining condition once the non-CDL benefit limit has been depleted - Migraine prophylaxis - Motor neuron disease - Neuropathy - Obsessive Compulsive Disorder - Osteoarthritis - Osteoporosis** - Paget's disease - Polyarthritis nodosa - Psoriasis - Psoriatic arthritis - Scleroderma - Sjogren's disease - Trigeminal neuralgia - Urinary incontinence Subject to: - Prior application and approval by the Scheme

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
				and benefits shall be from the date on which the application was received by the Scheme or its proxy.
2.3.2 Medicine for PMB conditions including the conditions listed on the chronic disease list (CDL)	Medicine on the formulary shall be covered at 100% Scheme tariff/cost* with no co-payment and voluntary use of non-formulary medicine shall be covered at 75% of Scheme tariff with a 25% co-payment. Subject to: Prior application and approval by the Scheme.	Medicine on the formulary shall be covered at 100% Scheme tariff/cost* with no co-payment and voluntary use of non-formulary medicine shall be covered at 80% of Scheme tariff with a 20% co-payment. Subject to: Prior application and approval by the Scheme.	Medicine on the formulary shall be covered at 100% Scheme tariff/cost* with no co-payment and voluntary use of non-formulary medicine shall be covered at 85% of Scheme tariff with a 15% co-payment. Subject to: Prior application and approval by the Scheme.	Medicine on the formulary shall be covered at 100% Scheme tariff/cost* with no co-payment and voluntary use of non-formulary medicine shall be covered at 90% of Scheme tariff with a 10% co-payment. Subject to: Prior application and approval by the Scheme.
2.3.3 Biological medicine: Biological medicine is a substance that is made from a living organism or its products and is used in the	Scheme pre-approval is required and out-of-hospital benefits are limited to the treatment of certain PMB	Subject to pre-approval, the benefits shall be paid at 100% of Scheme tariff/cost* with a maximum of	Subject to pre-approval, the benefits shall be paid at 100% of Scheme tariff/cost* with a maximum of R420 695	Subject to pre-approval, the benefits shall be paid at 100% of Scheme tariff/cost* with a

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
prevention, diagnosis, or treatment of acute and chronic diseases.	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.	R210 208 per beneficiary per financial year.	per beneficiary per financial year.	maximum of R622 628 per beneficiary per financial year.
2.3.4 Other high-cost medicine	Benefits shall be at 100% of Scheme tariff/cost* and subject to pre-approval.			
2.3.5 Acute medicine	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be subject to the overall day-to-day limit and the following maxima per financial year: M = R2 977 and M1+ = R6 161	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be subject to the overall day-to-day limit and the following maxima per financial year: M = R3 447 and M1+ = R6 893	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be subject to the overall day-to-day limit and the following maxima per financial year: M = R2 298 and M1+ = R5 169	Benefits shall be subject to the overall day-to-day limit and the following maxima per financial year: M = R10 732 and M1+ = R16 671 Benefits shall be for: - Medicine prescribed out of a hospital by a medical practitioner, a contracted

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	Benefits shall be for: - Medicine prescribed out of a hospital by a medical practitioner, a contracted Pharmacist Primary Care Drug Therapy (PCDT) pharmacist, dentist or a person authorised thereto by law. - Homeopathic remedies, injections and herbal remedies with Nappi code(s). - Benefits for homeopathic remedies, injections and herbal remedies without Nappi code(s) shall be paid from the Vested Medical Savings Account.	Benefits shall be for: - Medicine prescribed out of a hospital by a medical practitioner, a contracted Pharmacist Primary Care Drug Therapy (PCDT) pharmacist, dentist or a person authorised thereto by law. - Homeopathic remedies, injections and herbal remedies with Nappi code(s). - Benefits for homeopathic remedies, injections and herbal remedies without Nappi code(s) shall be paid from the Vested Medical Savings Account.	Benefits shall be for: - Medicine prescribed out of a hospital by a medical practitioner, a contracted Pharmacist Primary Care Drug Therapy (PCDT) pharmacist, dentist or a person authorised thereto by law at 100% Scheme tariff. - Homeopathic remedies, injections and herbal remedies with Nappi code(s) at 100% Scheme tariff. - Benefits for homeopathic remedies, injections and herbal remedies without Nappi code(s) shall be paid from the Vested Medical Savings Account.	Pharmacist Primary Care Drug Therapy (PCDT) pharmacist, dentist or a person authorised thereto by law at 90% Scheme tariff with a 10% co-payment. - Homeopathic remedies, injections and herbal remedies with Nappi code(s) at 90% Scheme tariff with a 10% co-payment.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.3.6 Over-the-counter (OTC) medicine The member may choose how to access OTC medicine benefits: 1. The OTC medicine benefit with a set limit on the PMSA. OR 2. The OTC medicine benefit without a set limit on the PMSA to accumulate a self-payment gap.	1. The OTC medicine benefit up to the limit of R1 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 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 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 2.7 of this Annexure, will contribute towards the payment of the self-payment gap, thus reducing and ultimately closing the self-payment gap. The Member			100% of the Scheme tariff, subject only to funds being available in the PMSA. Benefit includes, but not limited to, purchases of sunscreen, vitamins and minerals with Nappi codes on the Scheme's formulary.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	will only be able to access the Scheme's day-to-day benefits after contributing to the full amount of the self-payment gap. 2.3 The cost or Scheme tariff for services, whichever is lower, shall be used in the calculation of the contribution towards the self-payment gap: Non-contributing services or items shall not be taken into account in this calculation. 2.4 Where the annual PMSA is depleted, the Member will be liable for day-to-day claims (i.e. pay out of his own pocket) until he fully contributes to the self-payment gap amount. 2.5 The Member must continue to submit claims to the Scheme, even when the Member is in the self-payment gap, as this will inform the Scheme when the Member has fully contributed to the self-payment gap and consequently qualifies for the Scheme's day-to-day benefits. The claims must be submitted to the Scheme not later than the last day of the 4th (fourth) month following the month in which the relevant health service was rendered.			
2.4. PREVENTATIVE CARE AND WELLNESS BENEFITS	Benefits shall be at 100% of Scheme tariff and DSPs or preferred providers.			
2.4.1 Influenza vaccine	1 (one) vaccine per beneficiary per financial year.			
2.4.2 Pneumonia programme	Children under 2 (two) years of age: - As per the schedule of the Department of Health.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	Adult group: - Twice in a lifetime, with a booster if beneficiary is above 65 (sixty-five) years of age. - The Scheme in accordance with its protocol, will identify certain high-risk individuals who will be advised to be immunised.			
2.4.3 Travel vaccinations	Bestmed provides cover for certain mandatory travel vaccines for typhoid, yellow fever, tetanus, meningitis, hepatitis and cholera from Scheme risk benefits.			
2.4.4 Baby growth and development assessments	Children from 0 (zero) up to 2 (two) years of age: - 3 (three) assessments per year. - Assessments must be conducted at a pharmacy clinic or by a registered nurse.			
2.4.5 Paediatric immunisations	Paediatric vaccines according to the State recommended programme for babies and children.			
2.4.6 Female contraceptives	Applicable to all females of childbearing age: - 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 once every 5 (five) years.			
2.4.7 Preventative dentistry	Benefits are applicable per beneficiary: **1. General full mouth examination by a general dentist (incl. gloves and use of sterile equipment for this visit):** - 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.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	3. Intra-oral radiograph: All ages, 2 (two) x photos per financial year. **4. Scaling and/or polishing:** All ages, every 6 (six) months from the date of service. **5. Fluoride treatment:** All ages, every 6 (six) months from the date of service. **6. Fissure sealing:** Beneficiaries up to and including 21 (twenty-one) years, the frequency will be in accordance with accepted protocol. **7. Space maintainers:** During primary and mixed denture stage, once per space.			
2.4.8 HIV rapid test	Voluntary Testing and Counselling (VCT) as preventive care, subject to Scheme protocols and funding guidelines.			
2.4.9 Mammogram	Females 40 (forty) years and older - once every 24 (twenty-four) months.			
2.4.10 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).			
2.4.11 Bone densitometry	No benefit	Once every 24 (twenty-four) months for all beneficiaries 45 (forty-five) years and older.		
2.4.12 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 urologist or GP. Urologist or GP consultation paid from the available consultation benefit.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.4.13 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.			
2.4.14 PAP smear: Tariff codes claimed by pathologists or Nappi codes claimed by pharmacies in respect of this benefit are included.	Preventative benefit is subject to: - Females 18 (eighteen) years and older. - Once every 24 (twenty-four) months per beneficiary for PAP smear tariff code 4566 or 4559. - To be done at a gynaecologist or GP. - Consultation fee paid from the Preventative Care benefit.			
2.4.15 Glaucoma screening	No benefit	Preventative benefit is subject to: - Beneficiaries 50 (fifty) years and older. - Once every 12 (twelve) months per beneficiary. - To be performed by preferred optical network optometrists.		
2.4.16 Tempo programme: Benefits on the Tempo 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 a 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 biokineticists or nurses. - Beneficiaries must complete a lifestyle screening in order to unlock the biokineticist and dietician consultations that form			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	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.			
2.5 MATERNITY BENEFITS	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. - 1 (one) 2D ultrasound scan at 2nd (second) trimester (between 20 (twenty) to 24 (twenty-four) weeks) at a gynaecologist/GP/radiologist.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	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.			
2.6 OPTOMETRY BENEFITS	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 paid at 100% Scheme tariff subject to the maxima indicated.			
	Benefits from a PPN optometrist 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	Benefits from a PPN optometrist shall be as follows: - Consultations: 1 (one) per beneficiary at 100% of cost - Spectacle frames or lens enhancements limited to R1 325 AND - Lenses: standard lenses (i.e. single vision or bifocal or multifocal lenses) at 100% of cost as well as lens enhancements limited to R750 OR - Contact lenses limited to R2 280 Benefits from a non-network provider shall be as follows: - Consultations: 1 (one) per beneficiary limited to R420 - Spectacle frames or lens enhancements limited to R994 AND	Benefits from a PPN optometrist shall be as follows: - Consultations: 1 (one) per beneficiary at 100% of cost - Spectacle frames or lens enhancements limited to R1 325 AND - Lenses: standard lenses (i.e. single vision or bifocal or multifocal lenses) at 100% of cost as well as lens enhancements limited to R750 OR	

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Contact lenses limited to R2 085 Benefits from a non-network provider shall be as follows: - Consultations: 1 (one) per beneficiary limited to R420 - Spectacle frames or lens enhancements limited to R953 AND - Lenses: Single-vision lenses at R225 OR Bifocal lenses at R485 OR Multifocal lenses at R1 080 (consisting of R850 per base lens plus R230 per branded lens add-on)	- Lenses additional lens enhancements of R750: Single-vision lenses at R225 OR Bifocal lenses at R485 OR Multifocal lenses at R1 080 (consisting of R850 per base lens plus R230 per branded lens add-on) OR - In lieu of glasses Members can opt for contact lenses at R2 280		- Contact lenses limited to R2 700 Benefits from a non-network provider shall be as follows: - Consultations: 1 (one) per beneficiary limited to R420 - Spectacle frames or lens enhancements limited to R994 AND - Lenses additional lens enhancements of R750: Single-vision lenses at R225 OR Bifocal lenses at R485 OR Multifocal lenses at R1 080 (consisting of R850 per base lens plus R230 per branded lens add-on)

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	OR - In lieu of glasses Members can opt for contact lenses at R2 085			OR - In lieu of glasses Members can opt for contact lenses at R2 700
2.7 OUT-OF-HOSPITAL BENEFITS	- Refer to Annexure B.4 for the conditions of payment from the Personal Medical Savings Account (PMSA) and the Vested Medical Savings Account. - Full cross subsidisation between Members shall apply without an annual limit, except in relation to the PMSA. - Day-to-day benefits may be subject to payment from the PMSA first and shall be indicated as such. - Benefits may be subject to the annual maxima for the Member with his Dependant(s) and/or as provided for on the benefit. - Benefits shall be paid at 100% of Scheme tariff/cost* as per the standard of care in the State sector.			
	The following combined overall limit for day-to-day benefits shall apply per financial year: M = R13 794 and M1+= R27 586	The following combined overall limit for day-to-day benefits shall apply per financial year: M = R17 233 and M1+= R34 465	The following combined overall limit for day-to-day benefits shall apply per financial year: M = R23 028 and M1+= R47 590	The following combined overall limit for day-to-day benefits shall apply per financial year: M = R45 375 and M1+= R73 172
2.7.1 GP, nurse and specialist consultations	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the	Benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
Consultations, visits, diagnostic examinations, injections and emergency unit visits (where a procedure room was used) with General Practitioners, contracted Nursing Clinical Services, contracted Pharmacist Primary Care Drug Therapy (PCDT) pharmacists, Specialists, Homeopaths and Herbalists.	PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R2 840 and M1+ = R5 710	PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R5 260 and M1+ = R10 661	PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R5 561 and M1+ = R11 269	following maxima per financial year: M = R7 137 and M1+ = R11 570
2.7.2 Continuous/Flash Glucose Monitoring (CGM/FGM) benefit for Diabetics	Subject to the Medical Aids, apparatus and appliance benefit		Continuous/Flash Glucose Monitoring (CGM/FGM) at 100% of Scheme tariff limited to R24 286 per family per financial year, subject to Pre-authorisation.	Continuous/Flash Glucose Monitoring (CGM/FGM) at 100% of Scheme tariff limited to R30 357 per family per financial year, subject to Pre-authorisation.
2.7.3 Basic and specialised dentistry Includes basic and specialised dentistry not defined under Preventative dentistry benefits or	Basic and specialised dentistry benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at	Basic and specialised dentistry benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at	Basic and specialised dentistry benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at	Basic and specialised dentistry benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year:

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
Dental / Oral / Jaw surgical benefits.	100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R5 228 and M1+ = R10 609 Specialised dentistry benefits include: - Prosthodontics services (crowns, bridges, inlays, veneers and dentures); - Periodontics services (gum diseases); - Orthodontic services (correction of irregular teeth by means of braces, retainers or similar treatment) are subject to Pre-authorisation; and	100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R8 762 and M1+ = R17 527 Specialised dentistry benefits include: - Prosthodontics services (crowns, bridges, inlays, veneers and dentures); - Periodontics services (gum diseases); - Orthodontic services (correction of irregular teeth by means of braces, retainers or similar) for beneficiaries over the age of 18 (eighteen) years are	100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R9 442 and M1+ = R17 603 Specialised dentistry benefits include: - Prosthodontics services (crowns, bridges, inlays, veneers and dentures); - Periodontics services (gum diseases); - Orthodontic services (correction of irregular teeth by means of braces, retainers or similar) for beneficiaries over the age of 18 (eighteen) years are	M = R15 759 and M1+ = R26 598 Specialised dentistry benefits include: - Prosthodontics services (crowns, bridges, inlays, veneers and dentures); - Periodontics services (gum diseases); - Orthodontic services (correction of irregular teeth by means of braces, retainers or similar) for beneficiaries over the age of 18 (eighteen) years are subject to Pre-authorisation; and - Dental implants, implant costs and all laboratory costs related to the aforementioned services.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Dental implants, implant costs and all laboratory costs related to the aforementioned services.	subject to Pre-authorisation; and - Dental implants, implant costs and all laboratory costs related to the aforementioned services.	subject to Pre-authorisation; and - Dental implants, implant costs and all laboratory costs related to the aforementioned services.	
		Orthodontic services (correction of irregular teeth by means of braces, retainers, or similar treatment) for beneficiaries up to 18 (eighteen) years of age. Pre-authorisation is required and benefits shall be at 100% of Scheme tariff. Claims shall be paid from the PMSA first. Once the funds in the PMSA have been depleted, benefits shall be limited to R8 500 per event	Orthodontic services (correction of irregular teeth by means of braces, retainers, or similar treatment) for beneficiaries up to 18 (eighteen) years of age. Pre-authorisation is required and benefits shall be at 100% of Scheme tariff. Claims shall be paid from the PMSA first. Once the funds in the PMSA have been depleted, benefits shall be limited to R10 929 per event	Orthodontic services (correction of irregular teeth by means of braces, retainers, or similar treatment) for beneficiaries up to 18 (eighteen) years of age. Pre-authorisation is required and benefits shall be at 100% of Scheme tariff limited to R13 357 per event per financial year, subject to the overall day-to-day limit.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
		per financial year, subject to the overall day-to-day limit.	per financial year, subject to the overall day-to-day limit.	
2.7.4 Medical aids, apparatus and appliances, including wheelchairs and hearing aids Pre-authorisation must be obtained for all hearing aid devices fitted and the following documentation is required: - A fully detailed audiogram; - A comprehensive quotation, which includes, *inter alia*, the product name, clinical details (i.e. behind the ear, in the ear, custom) and the number of devices to be fitted; - Nappi code(s); - Motivation for obtaining a hearing aid device; and	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 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	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R13 221 per family per financial year for appliances that shall include any of the items listed below: - Back, leg, arm and neck support; - Surgical footwear; - Crutches; - Elastic stockings; - Repair work on artificial limbs, wheelchairs, etc.; - Stoma products, and - Oxygen and Diabetic supplies for non-PMB conditions.		Benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R13 221 per family per financial year for appliances that shall include any of the items listed below: - Back, leg, arm and neck support; - Surgical footwear; - Crutches; - Elastic stockings; - Repair work on artificial limbs, wheelchairs, etc.; - Stoma products, - Oxygen supplies and Diabetic supplies for non-PMB conditions; and - Insulin pump consumables.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
- In the case of providers who are not contracted with the Scheme, the product serial number(s) of the hearing aid device(s).	- Stoma products, Oxygen and Diabetic supplies for non-PMB conditions.	Wheelchairs at 100% of Scheme tariff limited to R17 880 per family every 48 (forty-eight) months.		
	Hearing aids and/or repair at 100% of Scheme tariff limited to R10 123 per family once every 24 (twenty-four) months. Pre-authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 2.7.4.	Hearing aids and/or repair at 100% of Scheme tariff limited to R33 472 per beneficiary every 24 (twenty-four) months. Pre-authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 2.7.4.		Hearing aids and/or repair at 100% of Scheme tariff limited to R36 610 per beneficiary every 24 (twenty-four) months. Pre-authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 2.7.4.
				Insulin pump, excluding consumables, at 100% of Scheme tariff limited to R53 143 per beneficiary every 24 (twenty-four) months. Pre-authorisation is required.
2.7.5 Supplementary services Benefits includes services rendered by physiotherapists,	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the	Benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
masseurs, chiropractors, osteopaths, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech therapists, biokinetics, private nursing (stoma therapy nursing, obtaining of specimen, observations and administration of medication, immunisations and IV's), psychiatric treatment, psychologists and social workers.	PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R5 574 and M1+ = R11 570	PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R4 021 and M1+ = R8 042	PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R3 396 and M1+ = R7 137	following maxima per financial year: M = R7 137 and M1+ = R14 048
2.7.6 Wound care benefit Includes dressings and negative pressure wound therapy (NPWT) treatment and nursing services out of hospital.	General wound care shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R4 583 per family per financial year.	General wound care 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 R8 245 per family per financial year.	General wound care shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R11 488 per family per financial year.	General wound care shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R17 429 per family per financial year. NPWT treatment shall be at 100% Scheme tariff, subject to Pre-authorisation.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	NPWT treatment shall be at 100% Scheme tariff, subject to Pre-authorisation.	NPWT treatment shall be at 100% Scheme tariff, subject to Pre-authorisation.	NPWT treatment shall be at 100% Scheme tariff, subject to Pre-authorisation.	
2.7.7 Basic radiology and pathology	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R4 132 and M1+ = R8 264		Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R4 508 and M1+ = R8 939	Benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R7 137 and M1+ = R14 048
2.7.8 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.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	Based on the first assessment, a rehabilitation treatment plan is drawn up and initiated over an uninterrupted period that will be specified by the provider.			
2.7.9 Rehabilitation after trauma Benefits for rehabilitation shall be aimed at the recovery of impeded vital functions immediately after trauma such as a stroke or heart attack.	Benefits shall be payable at 100% of Scheme tariff/cost*.			

* As per the provisions of Rule 2.1.8.