ANNEXURE B.2 – BENEFIT OPTIONS
2022 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.
- No benefits in respect of MRI scans and computer tomographic studies shall be granted if an authorisation number has not been obtained in advance or, in an emergency, on the 1st (first) working day after admission to a hospital, by the Scheme or its proxy.
- Full cross subsidisation between Members shall apply without an annual limit.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
- The Scheme's list of contracted private hospitals, contracted State facilities and designated and preferred service providers, available on the Scheme's website or via the Contact Centre, shall be applicable to benefits.				
2.2.1 Hospitalisation: Pre-authorisation must be obtained for accommodation (hospital stay) in a general ward, intensive-care and high-care unit, theatre and material.	Benefits shall be at 100% of Scheme tariff/cost*.			
2.2.2 Take-home medicine: Medicine supplied by the hospital when a patient is discharged.	Medicine prescribed by the treating provider for a patient discharged from hospital, relating to the admission, to take home will be paid at 100% of Scheme tariff/cost* for a maximum supply of 7 (seven) days.			
2.2.3 Biological medicine during hospitalisation A biological medicine is a substance that is made from a living organism or its products and is used in the prevention, diagnosis, or treatment of acute and chronic diseases.	Benefits shall be at 100% of Scheme tariff/cost*, subject to pre-approval and limited to R30 000 per family per financial year.	Benefits shall be at 100% of Scheme tariff/cost*, subject to pre-approval and the biologicals and other high-cost medicine benefit limit indicated on Rule 2.3.3.		
2.2.4 Treatment in mental health clinics	Benefits shall be at 100% of Scheme tariff/cost*, subject to the length of stay limited to 21 (twenty-one) days per beneficiary per financial year and Pre-Authorisation.			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.5 Treatment of chemical and substance abuse	Benefits shall be at 100% of Scheme tariff/cost*, subject to the following: - Pre-Authorisation; - DSPs; - The length of stay shall be limited to 21 (twenty-one) days for in-hospital or limited to R33 655 per beneficiary per financial year, whichever comes first. OR - 15 (fifteen) contact sessions for out-patient psychotherapy per condition, 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 Blood transfusion	Blood, operators' fees, transport charges and apparatus payable at 100% of Scheme tariff/cost*.			
2.2.9 Dental / Oral / Jaw surgery	- Pre-authorisation must be obtained for any surgical procedure that needs to be performed in a theatre and shall be payable at 100% of Scheme tariff.			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- 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.			
2.2.9.1 Dental and oral surgery (in and/or out of hospital):	Benefits shall be at 100% of Scheme tariff limited to R8 414 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;	Benefits shall be at 100% of Scheme tariff limited to R13 982 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;	Benefits shall be at 100% of Scheme tariff limited to R17 570 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;	Benefits shall be at 100% of Scheme tariff limited to R21 034 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; - Dental implant related surgery;

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Dental implant related surgery; - Pre-prosthetic (preparatory to dental prosthetics) surgery; - Orthodontic related / orthognathic surgery.	- Dental implant related surgery; - Pre-prosthetic (preparatory to dental prosthetics) surgery; - Orthodontic related / orthognathic surgery.	- Dental implant related surgery; - Pre-prosthetic (preparatory to dental prosthetics) surgery; - Orthodontic related / orthognathic surgery.	- Pre-prosthetic (preparatory to dental prosthetics) surgery; - Orthodontic related / orthognathic surgery.
2.2.9.2 Major medical maxilla-facial surgery	Benefits shall be at 100% of Scheme tariff limited to R13 610 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,	Benefits shall be at 100% of Scheme tariff strictly for the following conditions: - Severe trauma (soft tissue injuries, fractures of jaws and facial bones); - Cleft lip and palate; - Crouson's disease; - Malunited craniomaxillary disjunction; - Post-traumatic defects (root residues in sinus, secondary oro-nasal fistula, faciostenosis); - Internal TM joint surgery (condylectomy, arthrocentesis, arthroplasty, total joint reconstruction); - Salivary gland surgery (removal of gland or salivary stone); - Life threatening sepsis (Ludwig's angina); and - Confirmed oral cancer.		

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	secondary oro-nasal fistula, faciostenosis); - Internal TM joint surgery (condylectomy, arthrocentesis, arthroplasty, total joint reconstruction); - Salivary gland surgery (removal of gland or salivary stone); - Life threatening sepsis (Ludwig's angina); and - Confirmed oral cancer.			
2.2.10 Prosthesis Benefits	Benefits shall subject to the following: - Pre-authorisation; - Preferred providers or DSPs; - The treatment of certain PMB conditions, as per the standard of care in the State sector shall be paid at cost, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations; and - Services for non-PMB conditions shall be based on Scheme tariff or contracted fee and shall be subject to exclusions for joint replacement surgery.			
2.2.10.1 Prosthesis – Internal	Benefits shall not be pro-rated and shall be paid at	Benefits shall not be pro-rated and shall be paid at	Benefits shall not be pro-rated and shall be paid at	Benefits shall not be pro-rated and shall be paid at 100% of

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
Prosthesis surgically implanted during operations for the replacement of parts of the human body for functional medical reasons, including delivery systems and related items.	100% of Scheme tariff/cost* limited to the over-all limit of R94 036 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R34 273; - Pacemaker dual chamber limited to R58 526; - Endovascular and catheter based procedures and delivery mechanisms – no benefit; - Spinal prosthesis shall be limited to R34 273; - Artificial disks, spacers and similar devices – no benefit;	100% of Scheme tariff/cost* limited to the over-all limit of R120 762 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R45 286; - Pacemaker dual chamber shall be limited to R65 268; - Spinal prosthesis including artificial disk (single level based) shall be limited to R60 542; - Drug eluting stent shall be limited to R19 797; - Mesh shall be limited to R19 797;	100% of Scheme tariff/cost* limited to the over-all limit of R121 381 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R45 410; - Pacemaker dual chamber shall be limited to R65 268; - Spinal prosthesis including artificial disk (single level based) shall be limited to R60 657; - Drug eluting stent shall be limited to R19 797; - Mesh shall be limited to R19 797;	Scheme tariff/cost* limited to the over-all limit of R140 064 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R51 967; - Pacemaker dual chamber shall be limited to R65 268; - Spinal prosthesis including artificial disk (single level based) shall be limited to R70 038; - Drug eluting stent shall be limited to R23 324; - Mesh shall be limited to R20 539;

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Drug eluting stent – no benefit apart from PMB conditions and DSP products only; - Mesh shall be limited to R12 868; - Gynaecological/Urological prosthesis shall be limited to R9 280; - Lens implant shall be limited to R7 053 a lens per eye; - Functional prosthesis – items utilised towards treating or supporting a bodily function - shall be limited to R16 890.	- Gynaecological/Urological prosthesis shall be limited to R14 786; - Lens implant shall be limited to R12 695 a lens per eye; - Hip prosthesis and other major joints shall be limited to R54 380; - Knee prosthesis shall be limited to R63 103; - Other minor joints shall be limited to R23 447; and - Functional – items utilised towards treating or supporting a bodily function - shall be limited to R18 374.	- Gynaecological/Urological prosthesis shall be limited to R14 848; - Lens implant shall be limited to R12 695 a lens per eye; - Hip prosthesis and other major joints shall be limited to R54 442; - Knee prosthesis shall be limited to R63 413; - Other Minor joints shall be limited to R23 447; and - Functional – items utilised towards treating or supporting a bodily function - shall be limited to R19 797.	- Gynaecological/Urological prosthesis shall be limited to R16 952; - Lens implant shall be limited to R18 770 a lens per eye; - Hip prosthesis and other major joints shall be limited to R62 670; - Knee prosthesis shall be limited to R72 569; - Other Minor joints shall be limited to R23 324; and - Functional – items utilised towards treating or supporting a bodily function - shall be limited to R20 539.
2.2.10.2 Prosthesis – External: Prosthesis used after operations for the replacement of parts of the human body for functional medical	Benefits shall be at 100% of Scheme tariff limited to R23 881 per family per financial year:	Benefits shall be at 100% of Scheme tariff limited to R28 458 per family per financial year:	Benefits shall be at 100% of Scheme tariff limited to R28 583 per family per financial year:	Benefits shall be at 100% of Scheme tariff limited to R32 295 per family per financial year:

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
reasons, including delivery systems and related items. A list of prosthesis covered by the Scheme can be requested from the Scheme.	- 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 public hospital practice. - Repair work to artificial limbs will be funded from the Medical aids, apparatus and appliances benefit indicated in Rule 2.6.5.	- 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 public hospital practice. - Repair work to artificial limbs will be funded from the Medical aids, apparatus and appliances benefit indicated in Rule 2.6.5.	- 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 public hospital practice. - Repair work to artificial limbs will be funded from the Medical aids, apparatus and appliances benefit indicated in Rule 2.6.5.	- 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 public hospital practice. - Repair work to artificial limbs will be funded from the Medical aids, apparatus and appliances benefit indicated in Rule 2.6.5.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.10.3 Exclusions on joint replacement surgery for non-PMB conditions	No benefit for joint replacement surgery, except for PMBs, subject to the following prosthesis limits, which form part of the Prosthesis – Internal over-all limit, at 100% contracted fees: - Hip prosthesis and other major joints shall be limited to R34 892; - Knee prosthesis shall be limited to R46 400; and - Other minor joints shall be limited to R14 415.	Not applicable		
2.2.11 Medically necessary breast reduction surgery Including fees for the surgeon and anaesthetist	No benefit			Benefits shall be at 100% of Scheme tariff limited to R50 000 per family per financial year, subject to Pre-Authorisation and protocols.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.12 Orthopaedic and medical appliances during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost* for back, leg, arm and neck support, crutches, surgical footwear and elastic stockings provided before discharge from hospital.			
2.2.13 Pathology during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*.			
2.2.14 Basic radiology during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*.			
2.2.15 Specialised diagnostic imaging during hospitalisation	Benefits shall be at 100% of Scheme tariff for MRI scans, CT scans and isotope studies.			
2.2.16 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.			
2.2.17 Mammary surgery For breast cancer	No benefit for non-cancer breast.	Benefit shall be at 100% of Scheme tariff/cost* up to R38 294 for reconstructive surgery (which may include symmetrising, partial or total mastectomy, etc.) on the unaffected (non-cancerous) breast of a breast cancer patient. Benefit is subject to Pre-Authorisation and funding guideline.		
2.2.18 Peritoneal dialysis and haemodialysis (in or out of hospital)	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-Authorisation and designated or preferred service providers.			
2.2.19 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.			
2.2.20 Confinements	Benefits shall be at 100% of Scheme tariff/cost*, even if the baby dies before registration, for the following:			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- 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.			
2.2.21 Refractive surgery and all types of procedures to improve or stabilise vision, except for cataracts	Benefits shall be at 100% of Scheme tariff limited to R9 354 per eye, subject to Pre-Authorisation and protocols.	Benefits shall be at 100% of Scheme tariff limited to R9 774 per eye, subject to Pre-Authorisation and protocols.	Benefits shall be at 100% of Scheme tariff limited to R10 518 per eye, subject to Pre-Authorisation and protocols.	
2.2.22 Supplementary services during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*, provided that the claim is related to the hospital admission of the patient and is in line with the Scheme funding guidelines and protocols, for supplementary services which include services rendered by physiotherapists, masseurs, chiropractors, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech therapists, biokinetics, stoma therapist and social workers.			
2.2.23 Alternatives to hospitalisation	Benefits shall be at 100% of Scheme tariff subject to: - Pre-Authorisation; - Step-down facilities approved by the Scheme; and			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Services must be rendered by registered private nurses and hospices.			
2.2.24 Palliative care and home-based care in lieu of hospitalisation	Benefits shall be at 100% of Scheme tariff/cost* limited to R75 000 per beneficiary per financial year, subject to Pre-Authorisation.	Benefits shall be at 100% of Scheme tariff/cost* limited to R120 000 per beneficiary per financial year, subject to Pre-Authorisation.		
2.2.25 Ambulance and emergency evacuation services	Benefits shall be subject to: - Provision of benefits by ER24, as the Scheme's capitated preferred provider for ambulance services. - Benefits shall only be payable if the evacuation service was involuntarily requested and delivered by a service provider other than the preferred provider: Provided that services in respect of PMB conditions shall be payable at cost, without deductibles or the use of co-payments, subject to the provisions of Rule 15.10 of the main rules read in conjunction with Annexure D.1 of these Rules, as shall be evaluated by the Scheme.			
2.2.26 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 travel for emergency medical and related expenses: ▪ For 90 (ninety) days, excluding the United States of America (USA), is R5 million where there is only 1 (one) person, i.e. Member or Dependant and R10 million for a family i.e. Member and Dependant(s). ▪ For 45 (forty-five) days including the USA, R500 000 for a family i.e. Member and Dependant(s).			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Cover for business travel: emergency medical and related expenses: ▪ For 45 (forty-five) days excluding the USA is R5 million where there is only 1 (one) person, i.e. Member or Dependant and R10 million for a family i.e. Member and Dependant(s). - A Member must give at least 48 (forty-eight) hours in advance when he and/or his Dependant(s) are traveling overseas. Failure to do so will result in claims being rejected. - General exclusions to services apply. Elective planned procedures undergone outside of South Africa are not covered.			
1.2.27 Day procedures at a day hospital facility	Day procedures at a day hospital facility shall be funded at 100% of Scheme tariff/cost*, subject to: - Pre-Authorisation; - Protocols and funding guidelines; and - DSPs for PMBs Where procedures are done in a private hospital, funding shall be at day procedure tariff and may be subject to co-payments.			
2.3. MEDICINE BENEFITS Benefits for chronic, high-cost medicine, acute and over-the-counter (OTC) medicine shall be subject to: - Prior application and approval by the Scheme where indicated. - 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.				

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
- Where medicines have generic alternatives registered with the South African Health Products Regulatory Authority (SAHPRA), the Scheme will reimburse those medicines up to the MRP for that active ingredient. - Benefit amount for medicine will be calculated at Single Exit Price (SEP), plus the dispensing fee as negotiated by the Scheme, plus VAT. - DSPs may apply. - Each prescription or repeat prescription shall be limited to one month's supply per beneficiary. The Scheme may, at its sole discretion and according to the relevant protocols, grant an advance supply of medicine upon receipt of the relevant application. - Non-CDL medicine benefits will apply for the conditions indicated with double asterisks (**) where provision is not made in the Diagnosis and Treatment Pairs constituting the PMB package as listed in the Medical Schemes Act. - Approved PMB, CDL and non-CDL chronic medicine costs shall be paid from the non-CDL limit first. Thereafter, only approved PMB and CDL chronic medicine costs shall be paid by the Scheme. Approved 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 and other high-cost medicine limit first. Thereafter, only approved PMB biological medicine costs shall be paid by the Scheme.				
2.3.1 Chronic medicine not listed on the chronic disease list ("non-CDL medicine")	Medicine on the formulary shall be covered at 90% of Scheme tariff with a 10% co-payment and non-formulary medicine shall be covered at 75% of Scheme tariff with a 25% co-payment.	Medicine on the formulary shall be covered at 90% of Scheme tariff with a 10% co-payment and non-formulary medicine shall be covered at 80% of Scheme tariff with a 20% co-payment.	Medicine on the formulary shall be covered at 90% of Scheme tariff with a 10% co-payment and non-formulary medicine shall be covered at 85% of Scheme tariff with a 15% co-payment.	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

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	Payment shall be at Scheme tariff limited to M = R6 929 and M1+ = R13 858 for the following 7 (seven) non-CDL conditions: - Acne - Allergic rhinitis - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Eczema - Gout Prophylaxis** - Major Depression** shall be covered as a life-sustaining condition once the non-CDL benefit limit has been depleted	Payment shall be at Scheme tariff limited to M = R9 528 and M1+ = R19 055 for the following 20 (twenty) non-CDL conditions: - Acne - Allergic rhinitis - Ankylosing Spondylitis - Alzheimer's disease - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Autism - Collagen diseases - Dermatomyositis - Eczema	Payment shall be at Scheme tariff limited to M = R15 368 and M1+ = R30 735 for the following 20 (twenty) non-CDL conditions: - Acne - Allergic rhinitis - Ankylosing Spondylitis - Alzheimer's disease - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Autism - Collagen diseases - Dermatomyositis - Eczema	M = R20 724 and M1+ = R41 636 for the following 29 (twenty-nine) non-CDL conditions: - Acne - 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 - Gastro Oesophageal Reflux Disease (GORD)**

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- 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.	- Gastro Oesophageal Reflux Disease (GORD)** - Gout Prophylaxis** - Major Depression** shall be covered as a 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:	- Gastro Oesophageal Reflux Disease (GORD)** - Gout Prophylaxis** - Major Depression** shall be covered as a 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:	- Gout Prophylaxis** - Hypopituitarism - Major Depression** shall be covered as a life-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

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.	- 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.	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.
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.

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.3.3 Biologicals and other high-cost medicine: A biological medicine is a substance that is made from a living organism or its products and is used in the prevention, diagnosis, or treatment of acute and chronic diseases; and A high cost medicine is any costly medicine that the Scheme has classified as such and is only covered under this benefit, i.e. the high cost benefit.	Scheme pre-approval is required and 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.	Subject to pre-approval, the benefits shall be paid at 100% of Scheme tariff/cost* with a maximum of R173 110 per beneficiary per financial year.	Subject to pre-approval, the benefits shall be paid at 100% of Scheme tariff/cost* with a maximum of R346 449 per beneficiary per financial year.	Subject to pre-approval, the benefits shall be paid at 100% of Scheme tariff/cost* with a maximum of R512 744 per beneficiary per financial year.
2.3.4 Acute medicine	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall subject to the overall day-to-day limit and the following maxima per financial year:	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be subject to the overall day-to-day limit and the following maxima per financial year:	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be subject to the overall day-to-day limit and the following maxima per financial year:	Benefits shall be subject to the overall day-to-day limit and the following maxima per financial year: M = R9 280 and M1+ = R14 415

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	M = R2 451 and M1+ = R5 074 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	M = R5 074 and M1+ = R10 146 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	M = R1 609 and M1+ = R3 960 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	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 90% Scheme tariff with a 10% co-payment. - Homeopathic remedies, injections and herbal remedies with nappi code(s) at 90% Scheme tariff with a 10% co-payment.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	paid from the Vested Medical Savings Account.	paid from the Vested Medical Savings Account.	nappi code(s) shall be paid from the Vested Medical Savings Account.	
2.3.5 Over-the-counter (OTC) medicine The member must choose how to access OTC medicine benefits: 1. The OTC medicine benefit with a set limit on the PMSA. OR 2. The OTC medicine benefit without a set limit on the PMSA to accumulate a self-payment gap.	1. The OTC medicine benefit up to the limit of R1 000 per family per financial year, paid at 100% of Scheme tariff from the PMSA. Benefit includes purchases of sunscreen, vitamins and minerals with nappi codes on the Scheme's formulary. 1.1 Once the set limit has been reached, the member may access further medicine benefits through the Acute medicine benefit, or the Vested Medical Savings Account where purchases shall be paid at 100% Scheme tariff. OR 2. OTC medicine benefit without a limit on the PMSA to accumulate a self-payment gap once the limit of R1 000 has been reached. 2.1 The threshold will be determined by the amount allocated to the annual PMSA at the beginning of the year, or pro-rated if the Member joins after January, from which OTC medicine purchases, in excess of the aforementioned set limit, will accumulate to a self-payment gap.			100% of the Scheme tariff, subject only to funds being available in the PMSA. Benefit includes purchases of sunscreen, vitamins and minerals with nappi codes on the Scheme's formulary.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	2.2 Once a self-payment gap has accumulated, the day-to-day health care services, as indicated in Rule 2.6 of this Annexure, will contribute towards the payment of the self-payment gap, thus reducing and ultimately closing the self-payment gap. The Member will only be able to access the Scheme's day-to-day benefits after contributing to the full amount of the self-payment gap. 2.3 The cost or Scheme tariff for services, whichever is lower, shall be used in the calculation of the contribution towards the self-payment gap: Non-contributing services or items shall not be taken into account in this calculation. 2.4 Where the annual PMSA is depleted, the Member will be liable for day-to-day claims (i.e. pay out of his own pocket) until he fully contributes to the self-payment gap amount. 2.5 The Member must continue to submit claims to the Scheme, even when the Member is in the self-payment gap, as this will inform the Scheme when the Member has fully contributed to the self-payment gap and consequently qualifies for the Scheme's day-to-day benefits. The claims must be submitted to the Scheme not later than the last day of the 4th (fourth) month following the month in which the relevant health service was rendered.			
2.4. PREVENTATIVE CARE AND WELLNESS BENEFITS	Benefits shall be at 100% of Scheme tariff.			
2.4.1 Influenza vaccine	1 (one) vaccine per beneficiary per financial year.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.4.2 Pneumonia programme	Children under 2 (two) years of age: - As per the schedule of the Department of Health. Adult group: - Twice in a lifetime, with a booster if beneficiary is above 65 (sixty-five) years of age. - The Scheme in accordance with its protocol, will identify certain high-risk individuals who will be advised to be immunised.			
2.4.3 Travel vaccinations	Bestmed provides cover for certain mandatory travel vaccines for typhoid, yellow fever, tetanus, meningitis, hepatitis and cholera from Scheme risk benefits.			
2.4.4 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 Tempo partner pharmacy clinic.			
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: - Quantity and frequency depending on product up to the maximum of R2 412 per beneficiary per financial year, which includes all items classified in category of female contraceptives. - Mirena device – 1 (one) device in 60 (sixty) months.			
2.4.7 Back and neck preventative programme	Applicable to all ages – subject to Pre-Authorisation: - Preferred providers, i.e. DBC or Workability clinics. - Applicable to beneficiaries with serious spinal and/or back problems that may require surgery and use of this programme is in lieu of surgery. - The Scheme may identify appropriate participants for evaluation at a DBC or Workability clinic.			

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.			
2.4.8 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. **3. Intra-oral radiograph:** All ages, 2 (two) x photos per financial year. **4. Scaling and/or polishing:** All ages, twice per financial year. **5. Fluoride treatment:** All ages, twice per financial year. **6. Fissure sealing:** Beneficiaries up to and including 21 (twenty-one) years, the frequency will be in accordance with accepted protocol.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	7. Space maintainers: During primary and mixed denture stage, once per space.			
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 50 (fifty) years and older: - Once every 24 (twenty-four) months per beneficiary. - To be done at urologist. Urologist consultation paid from the consultation benefit.			
2.4.13 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. - To be done at a gynaecologist or general practitioner. - Consultation fee paid from the consultation benefit, subject to PMBs. Benefits in respect of PMBs for shall be paid from the applicable Scheme benefits.			
2.4.14 Tempo wellness programme:	**1. Health risk assessments** Beneficiaries 16 (sixteen) years and older			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
Benefits on the Tempo wellness programme can only be accessed when a beneficiary undergoes a health risk assessment.	- 1 (one) per beneficiary per financial year for beneficiaries 16 (sixteen) years and older. - Biometric screening and lifestyle questionnaire must be completed at Wellness Network pharmacies, onsite at selected Employer Groups or at a Tempo biokineticist. - Beneficiaries must complete a health risk assessment in order to unlock the rest of the Tempo wellness programme benefits. **2. Fitness and nutritional interventions available to beneficiaries 16 (sixteen) years and older** Fitness - 1 (one) fitness test at a Tempo biokineticist; and - 2 (two) follow-up virtual consultations at a Tempo biokineticist. Nutrition - 1 (one) nutritional assessment at a Tempo dietician; and - 2 (two) follow-up virtual consultations at a Tempo dietician. **3. Tempo group classes** Scheduled throughout the year to encourage and support a healthier lifestyle available to all beneficiaries.			
2.4.15 Maternity benefits	Benefits shall be at 100% of Scheme tariff per beneficiary per financial year, subject to the following: Consultations: - 9 (nine) antenatal consultations at either a GP/gynaecologist/midwife. - 1 (one) post-natal consultation at either a GP/gynaecologist/midwife. - 1 (one) lactation consultation with a registered nurse or a lactation specialist.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	Ultrasounds: - 1 (one) 2D ultrasound scan at 1st (first) trimester (between 10 (ten) to 12 (twelve) weeks) at a gynaecologist/GP/radiologist. - 1 (one) 2D ultrasound scan at 2nd (second) trimester (between 20 (twenty) to 24 (twenty-four) weeks) at a gynaecologist/GP/radiologist. Any item categorised as a maternity supplement can be claimed up to a maximum of R120 per claim, once a month, for a maximum of 9 (nine) months.			
2.5 OPTOMETRY BENEFITS	Optometry benefits are available per beneficiary every 24 (twenty-four) months from the date of service. Services rendered by Preferred Provider Negotiators (PPN) network optometrists shall be payable at 100% of contracted fee. Services rendered by a non-network provider shall be paid at 100% Scheme tariff subject to the maxima indicated. The maximum amount indicated for contact lenses shall be applicable, irrespective if the beneficiary obtained services from a PPN network optometrist or a non–network provider.			
	Benefits from a PPN network optometrist shall be as follows: - Consultations: 1 (one) per beneficiary at 100% of cost	Benefits from a PPN network optometrist shall be as follows: - Consultations: 1 (one) per beneficiary at 100% of cost - Spectacle frames or lens enhancements limited to R990 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	Benefits from a PPN network optometrist shall be as follows: - Consultations: 1 (one) per beneficiary at 100% of cost - Spectacle frames or lens enhancements limited to R990 AND	

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Spectacle frames or lens enhancements limited to R950 AND - Lenses: standard lenses (i.e. single vision or bifocal or multifocal lenses) at 100% of cost OR - Contact lenses limited to R1 720 Benefits from a non-network provider shall be as follows: - Consultations: 1 (one) per beneficiary limited to R350 - Spectacle frames or lens enhancements limited to R598 AND - Lenses:	- Contact lenses limited to R1 880 Benefits from a non-network provider shall be as follows: - Consultations: 1 (one) per beneficiary limited to R350 - Spectacle frames or lens enhancements limited to R598 AND - Lenses: Single-vision lenses at R210 OR Bifocal lenses at R445 OR Multifocal lenses at R1 000 - In lieu of glasses Members can opt for contact lenses at R1 880		- 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 220 Benefits from a non-network provider shall be as follows: - Consultations: 1 (one) per beneficiary limited to R350 - Spectacle frames or lens enhancements limited to R598 AND - Lenses: Single-vision lenses at R210 OR

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	Single-vision lenses at R210 OR Bifocal lenses at R445 OR Multifocal lenses at R1 000 - In lieu of glasses Members can opt for contact lenses at R1 720			Bifocal lenses at R445 OR Multifocal lenses at R1 000 - In lieu of glasses Members can opt for contact lenses at R2 220
2.6 OUT-OF-HOSPITAL BENEFITS	- Refer to Annexure B.4 for the conditions of payment from the Personal Medical Savings Account (PMSA) and the Vested Medical Savings Account. - Full cross subsidisation between Members shall apply without an annual limit, except in relation to the PMSA. - Day-to-day benefits may be subject to payment from the PMSA first and shall be indicated as such. - Benefits may be subject to the annual maxima for the Member with his Dependant(s) and/or as provided for on the benefit. - Benefits shall be paid at 100% of Scheme tariff/cost* as per the standard of care in the State sector.			
	The following combined overall limit for day-to-day benefits shall apply per financial year:	The following combined overall limit for day-to-day benefits shall apply per financial year:	The following combined overall limit for day-to-day benefits shall apply per financial year:	The following combined overall limit for day-to-day benefits shall apply per financial year:

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	M = R11 359 and M1+= R22 717	M = R16 036 and M1+= R32 071	M = R20 045 and M1+= R41 425	M = R37 367 and M1+= R60 258
2.6.1 GP, nurse and specialist consultations Consultations, visits, diagnostic examinations, injections and emergency unit visits (where a procedure room was used) with General Practitioners, contracted Nursing Clinical Services, contracted Pharmacist Primary Care Drug Therapy (PCDT) pharmacists, Specialists, Homeopaths and Herbalists.	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R2 339 and M1+ = R4 702	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 579 and M1+ = R9 280		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 877 and M1+ = R9 528
2.6.2 Diabetes primary care consultation	Benefits shall be at 100% of Scheme tariff subject to: - Registration with HaloCare in order to access 2 (two) primary care consultations at Dis-Chem Pharmacies per financial year. - The consultation shall be paid first from the “GP, nurse and specialist consultations” day-to-day benefit maxima and thereafter Scheme risk.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.6.3 Continuous/Flash Glucose Monitoring (CGM/FGM) benefit for Diabetics	No benefit		Continuous/Flash Glucose Monitoring (CGM/FGM) at 100% of Scheme tariff limited to R20 000 per family per financial year, subject to Pre-Authorisation.	Continuous/Flash Glucose Monitoring (CGM/FGM) at 100% of Scheme tariff limited to R25 000 per family per financial year, subject to Pre-Authorisation.
2.6.4 Basic and specialised dentistry This benefit covers basic and specialised dentistry not defined under Preventative dentistry benefits or Dental / Oral / Jaw surgical benefits.	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 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R4 305 and M1+ = R8 736 Specialised dentistry benefits include:	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 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R7 217 and M1+ = R14 433 Specialised dentistry benefits include:	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 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R7 776 and M1+ = R14 497 Specialised dentistry benefits include:	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: M = R12 977 and M1+ = R21 903 Specialised dentistry benefits include: - Prosthodontics services (crowns, bridges, inlays, veneers and dentures);

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- 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 - Dental implants, implant costs and all laboratory costs related to the aforementioned services.	- Prosthodontics services (crowns, bridges, inlays, veneers and dentures); - Periodontics services (gum diseases); and - Dental implants, implant costs and all laboratory costs related to the aforementioned services.	- Prosthodontics services (crowns, bridges, inlays, veneers and dentures); - Periodontics services (gum diseases); and - Dental implants, implant costs and all laboratory costs related to the aforementioned services.	- Periodontics services (gum diseases); 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. Benefits shall be at 100% of Scheme tariff limited to R7 000 per event per annum for beneficiaries up to 18 (eighteen) years of age. Subject to Pre-Authorisation and the overall day-to-day limit.	Orthodontic services: correction of irregular teeth by means of braces, retainers, or similar treatment. Benefits shall be at 100% of Scheme tariff limited to R9 000 per event per annum for beneficiaries up to 18 (eighteen) years of age. Subject to Pre-Authorisation and the overall day-to-day limit.	Orthodontic services: correction of irregular teeth by means of braces, retainers, or similar treatment. Benefits shall be at 100% of Scheme tariff limited to R11 000 per event per annum for beneficiaries up to 18 (eighteen) years of age. Subject to Pre-Authorisation and the overall day-to-day limit.

<table>
<tr><th>HEALTHCARE SERVICES</th><th>PACE1</th><th>PACE2</th><th>PACE3</th><th>PACE4</th></tr>
<tr><td>2.6.5 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
- In the case of providers who are not contracted with the Scheme,</td><td>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 R12 003 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</td><td colspan="2">Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R10 888 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.</td><td>Benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R10 888 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.</td></tr>
<tr><td colspan="4">Wheelchairs at 100% of Scheme tariff limited to R14 725 per family every 48 (forty-eight) months.</td></tr>
</table>

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
the product serial number(s) of the hearing aid device(s).	- Stoma products, Oxygen and Diabetic supplies for non-PMB conditions.			
	Hearing aids and/or repair at 100% of Scheme tariff limited to R8 336 per family once every 24 (twenty-four) months. Pre-Authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 2.6.5.	Hearing aids and/or repair at 100% of Scheme tariff limited to R30 005 per beneficiary every 24 (twenty-four) months. Pre-Authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 2.6.5.	Hearing aids and/or repair at 100% of Scheme tariff limited to R33 779 per beneficiary every 24 (twenty-four) months. Pre-Authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 2.6.5.	Hearing aids and/or repair at 100% of Scheme tariff limited to R37 614 per beneficiary every 24 (twenty-four) months. Pre-Authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 2.6.5.
				Insulin pump, excluding consumables, at 100% of Scheme tariff limited to R43 764 per beneficiary every 24 (twenty-four) months. Pre-Authorisation is required.
2.6.6 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, 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 = R4 590 and M1+ = R9 528	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 755 and M1+ = R11 569	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 797 and M1+ = R5 877	following maxima per financial year: M = R5 877 and M1+ = R11 569
2.6.7 Wound care benefit Includes dressings and negative pressure wound therapy (NWPT) treatment and nursing services out of hospital.	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R3 774 per family per financial year.	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R7 176 per family per financial year.	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R11 136 per family per financial year.	Benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R14 353 per family per financial year.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.6.8 Basic radiology and pathology	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R3 402 and M1+ = R6 806		Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R3 712 and M1+ = R7 362	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 877 and M1+ = R11 569
2.6.9 Specialised diagnostic imaging MRI scans, CT scans, PET scans and isotope studies.	Benefits shall be at 100% of Scheme tariff limited to R15 220 per family per financial year.	Benefits shall be at 100% of Scheme tariff limited subject to the following: - MRI scans and CT scans shall be limited to 3 (three) scans per beneficiary; - PET scans shall be limited to 1 (one) scan per beneficiary; and - A pre-authorisation for any specialised radiology must be obtained from the Scheme or its proxy.		
2.6.10 Rehabilitation after trauma	Benefits shall be payable at 100% of Scheme tariff/cost*.			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
Benefits for rehabilitation shall be aimed at the recovery of impeded vital functions immediately after trauma such as a stroke or heart attack.				