ANNEXURE B.3 – BENEFIT OPTIONS
2022 PULSE RANGE

3.1 GENERAL CONDITIONS OF THE BENEFIT OPTIONS

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

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

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

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

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

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

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

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

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

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

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

HEALTHCARE SERVICES	PULSE1

3.2 HOSPITAL, HOSPITAL-RELATED BENEFITS AND OTHER MAJOR MEDICAL EXPENSES

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

HEALTHCARE SERVICES	PULSE1
- The Scheme's list of Hospital Network DSP (contracted private hospitals and contracted State facilities) and designated and preferred service providers available on the Scheme's website or via the Contact Centre, shall be applicable to benefits. - Co-payments: ▪ A co-payment of R12 373 shall apply on the Pulse1 benefit option for the voluntary use of a non-designated Hospital Network, i.e. where a Member or his Dependant(s) voluntarily choose not to make use of a hospital forming part of the Hospital Network.	
3.2.1 Hospitalisation: Pre-authorisation required for accommodation (hospital stay) in a general ward, intensive-care and high-care unit, theatre and material.	Benefits shall be at 100% of Scheme tariff/cost*. DSP Network applies.
3.2.2 Take-home medicine: Medicine supplied by the hospital when a patient is discharged.	Medicine prescribed by the treating provider for a patient discharged from hospital, relating to the admission, to take home will be paid at 100% of Scheme tariff/cost* for a maximum supply of 3 (three) days.
3.2.3 Biological medicine during hospitalisation 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 R15 000 per family per financial year.
3.2.4 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.
3.2.5 Treatment of chemical and substance abuse	Benefits shall be limited to the treatment of PMB conditions and subject to the following:

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	PULSE1
	- Pre-Authorisation; - DSP Network; and - The length of stay shall be limited to 21 (twenty-one) days for in-hospital or 15 (fifteen) contact sessions for out-patient psychotherapy per condition, per beneficiary per financial year.
3.2.6 Consultations and procedures: Consultations, visits, operations, surgical procedures and anaesthetics for surgical procedures during hospitalisation.	Claims submitted by General Practitioners (GPs) and specialists for treatment during hospitalisation shall be paid at 100% of Scheme tariff/cost*. DSP Network applies.
3.2.7 Organ transplants (in and/or out of hospital): Pre-authorisation must be obtained.	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules underlined by PMB regulations, and shall be paid at cost.
3.2.8 Blood transfusion	Blood, operators' fees, transport charges and apparatus payable at 100% of Scheme tariff/cost*.
3.2.9 Dental / Oral / Jaw surgery	- Pre-authorisation must be obtained for any surgical procedure that needs to be performed in a theatre and shall be payable at 100% Scheme tariff. - The treatment of certain PMB conditions, as per the standard of care in the State sector shall be paid at cost, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations.
3.2.9.1 Dental and oral surgery (in and/or out of hospital)	No benefit
3.2.9.2 Major medical maxilla-facial surgery	No benefit, except in respect of PMB conditions.

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	PULSE1
3.2.10 Prosthesis Benefits	Benefits are subject to the following: - Pre-authorisation; - Preferred providers or DSPs; - Services for non-PMB conditions shall be based on Scheme tariff or contracted fee and may be subject to exclusions for joint replacement surgery; and - The treatment of certain PMB conditions, as per the standard of care in the State sector shall be paid at cost, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations.
3.2.10.1 Prosthesis – Internal Prosthesis surgically implanted during operations for the replacement of parts of the human body for functional medical reasons, including delivery systems and related items.	Benefits shall not be pro-rated and shall be paid at 100% of Scheme tariff/cost* limited to the over-all limit of R55 309 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R27 406; - Pacemaker dual chamber limited to R44 791; - Endovascular and catheter based procedures and delivery mechanisms – no benefit; - Spinal prosthesis shall be limited to R27 406; - Artificial disks, spacers and similar devices – no benefit; - Drug eluting stent – no benefit apart from PMB conditions and DSP products only; - Mesh shall be limited to R10 023;

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	PULSE1
	- Gynaecological/Urological prosthesis shall be limited to R8 278; - Lens implant shall be limited to R5 755 a lens per eye; - Functional prosthesis – items utilised towards treating or supporting a bodily function - shall be limited to R11 755.
3.2.10.2 Prosthesis – External: Prosthesis used after operations for the replacement of parts of the human body for functional medical reasons, including delivery systems and related items. A list of prosthesis covered by the Scheme can be requested from the Scheme.	No benefit, except in respect of PMB conditions.
3.2.10.3 Exclusions on joint replacement surgery for non-PMB conditions	No benefit for joint replacement surgery, except for PMBs, subject to the following prosthesis limits at 100% contracted fees: - Hip prosthesis and other major joints shall be limited to R28 088; - Knee prostheses shall be limited to R35 512; and - Other minor joints shall be limited to R13 301. Functional nasal surgery and surgery procedures where CNS stimulators are used for example epilepsy, Parkinsonism, etc. will be excluded from benefits except for PMB conditions.
3.2.11 Orthopaedic and medical appliances during hospitalisation Pre-authorisation must be obtained.	Benefits shall be at 100% of Scheme tariff/cost* limited to R6 806 per family per financial year for the items listed below, if prescribed by a medical practitioner and where such a prescription forms part of the in hospital treatment.

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	PULSE1
	- Back, leg, arm and neck support; - Crutches; - Surgical footwear (excluding health footwear); - Elastic stockings; - Oxygen, diabetic and stoma aids continually essential for the medical treatment of the patient; and - Medical apparatus continually essential for the medical treatment of the patient.
3.2.12 Pathology during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*.
3.2.13 Basic radiology during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*.
3.2.14 Specialised diagnostic imaging during hospitalisation	Benefits shall be at 100% of Scheme tariff for MRI scans, CT scans and isotope studies, subject to Pre-Authorisation.
3.2.15 Oncology benefits (in or out of hospital)	Oncology Programme. Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-Authorisation and designated or preferred service providers.
3.2.16 Peritoneal dialysis and haemodialysis (in or out of hospital)	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-Authorisation and designated or preferred service providers.
3.2.17 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.

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	PULSE1
3.2.18 Confinements	Benefits shall be at 100% of Scheme tariff/cost*, even if the baby dies before registration, for the following: - Medical practitioners; - Nursing home and hospital fees in accordance with the provisions of the "Hospitalisation" benefit; - Midwife assisted births in an Active Hospital Birth Unit or home confinement by a midwife. Transport fees, hospital facility fees, renting of a birth pool, medical disposables or medication, antenatal consultations, doulas and breastfeeding support shall be excluded from benefits if these are not PMB level of care; and - Midwife assisted births at a private midwife birth house. Transport fees, renting of a birth pool, antenatal consultations, doulas and breastfeeding supports shall be excluded from benefits if these are not PMB level of care.
3.2.19 Refractive surgery and all types of procedures to improve or stabilise vision, except for cataracts	No benefit, except in respect of PMB conditions.
3.2.20 Supplementary Services during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*, provided that the claim is related to the hospital admission of the patient and is in line with the Scheme funding guidelines and protocols, for supplementary services which include services rendered by physiotherapists, masseurs, chiropractors, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech therapists, biokinetics, stoma therapist and social workers.
3.2.21 Alternatives to hospitalisation	Benefits shall be at 100% of Scheme tariff subject to:

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	PULSE1
	- Pre-Authorisation; - Step-down facilities approved by the Scheme; and - Services must be rendered by registered private nurses and hospices.
3.2.22 Palliative care and home-based care in lieu of hospitalisation	Benefits shall be at 100% of Scheme tariff/cost* limited to R60 000 per beneficiary per financial year, subject to Pre-Authorisation.
3.2.23 Ambulance and emergency evacuation services	Benefits shall be subject to: - Provision of benefits by ER24, as the Scheme's capitated preferred provider for ambulance services. - Benefits shall only be payable if the evacuation service was involuntarily requested and delivered by a service provider other than the preferred provider: Provided that services in respect of PMB conditions shall be payable at cost, without deductibles or the use of co-payments, subject to the provisions of Rule 15.10 of the main rules read in conjunction with Annexure D.1 of these Rules, as shall be evaluated by the Scheme.
3.2.24 International emergency medical cover	In addition to the provisions for foreign claims referred to in Rule 16.12 of the registered Bestmed Rules, the Member and his Dependant(s) qualify for additional benefits which shall be at 100% contracted tariff subject to the following: - Provision of benefits by Europ Assistance SA, as the Scheme's capitated preferred provider for international travel insurance. - Cover for leisure travel for emergency medical and related expenses:

HEALTHCARE SERVICES	PULSE1
	▪ 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). - 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 notify to do so will result in claims being rejected. - General exclusions to services apply. Elective planned procedures undergone outside of South Africa are not covered.
3.2.25 Day procedures at a day hospital facility	Day procedures at a day hospital facility shall be funded at 100% of Scheme tariff/cost*, subject to: - Pre-Authorisation; - Protocols and funding guidelines; and - 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.

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	PULSE1
3.2.26 Co-payments	A co-payment of R12 373 shall apply on the Pulse1 benefit option for the voluntary use of a non-designated Hospital Network, i.e. where a Member or his Dependant(s) voluntarily choose not to make use of a hospital forming part of the Hospital Network.

3.3. MEDICINE BENEFITS

Benefits for chronic, high-cost medicine, acute and over-the-counter (OTC) medicine shall be subject to:

- Prior application and approval by the Scheme where indicated.
- The Scheme treatment protocols and clinical funding guidelines. Motivations and reports by appropriate medical practitioners may be requested by the Scheme.
- The Scheme's formulary (medicine list), where applicable.
- Where medicines have generic alternatives registered with the South African Health Products Regulatory Authority (SAHPRA), the Scheme will reimburse those medicines up to the MRP for that active ingredient.
- Benefit amount for medicine will be calculated at Single Exit Price (SEP), plus the dispensing fee as negotiated by the Scheme, plus VAT.
- DSPs may apply - Members choosing the Network options are required to make use of Scheme-contracted pharmacies to obtain their medicine.
- 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.

HEALTHCARE SERVICES	PULSE1
- Approved PMB biological and non-PMB biological medicine costs shall be paid from the applicable biological and other high-cost medicine limit first. Thereafter, only approved PMB biological medicine costs shall be paid by the Scheme.	
3.3.1 Chronic medicine not listed on the chronic disease list ("non-CDL medicine")	No benefit
3.3.2 Medicine for PMB conditions including the conditions listed on the chronic disease list (CDL)	Medicine on the formulary shall be covered at 100% of Scheme tariff/cost* with no co-payment and voluntary use of non-formulary medicine shall be covered at 70% of Scheme tariff with a 30% co-payment. Subject to: - Prior application and approval by the Scheme.
3.3.3 Biologicals and other high-cost medicine out of hospital: 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.
3.3.4 Acute medicine	Benefits shall be at 100% of Scheme tariff, for:

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	PULSE1
	- Medicine on the formulary prescribed out of a hospital by a medical practitioner, a dentist or a person authorised thereto by law. - No benefit shall apply to non-formulary acute medicine.
3.3.5 Over-the-counter (OTC) medicine	Benefits shall be at 100% of Scheme tariff up to the limit of R600 per family per annum, at a preferred provider pharmacy network. Benefit includes purchases of sunscreen, vitamins and minerals with nappi codes on the Scheme's formulary.
3.4. PREVENTATIVE CARE AND WELLNESS BENEFITS	Benefits shall be at 100% of Scheme tariff.
3.4.1 Influenza vaccine	1 (one) vaccine per beneficiary per financial year.
3.4.2 Pneumonia Programme	Children under 2 (two) years of age: - As per the schedule of the Department of Health. Adult group: - Twice in a lifetime, with a booster if beneficiary is above 65 (sixty-five) years of age. - The Scheme in accordance with its protocol, will identify certain high-risk individuals who will be advised to be immunised.
3.4.3 Travel vaccinations	Bestmed provides cover for certain mandatory travel vaccines for typhoid, yellow fever, tetanus, meningitis, hepatitis and cholera from Scheme risk benefits.
3.4.4 Paediatric immunisations	Paediatric vaccines according to the State recommended programme for babies and children.
3.4.5 Baby growth and development assessments	Children from 0 (zero) up to 2 (two) years of age: - 3 (three) assessments per year. - Assessments must be conducted at a Tempo partner pharmacy clinic.

HEALTHCARE SERVICES	PULSE1
3.4.6 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.
3.4.7 Mammogram	Females 40 (forty) years and older - once every 24 (twenty-four) months: - Only for tariff code 34100; and - Must be referred by a Network GP, a specialist that is part of the Pulse Specialist Network.
3.4.8 Back and neck preventative programme	Applicable to all ages – subject to Pre-Authorisation: - Preferred providers, i.e. DBC or Workability clinics. - Applicable to beneficiaries with serious spinal and/or back problems that may require surgery and use of this programme is in lieu of surgery. - The Scheme may identify appropriate participants for evaluation at a DBC or Workability clinic. - Based on the first assessment, a rehabilitation treatment plan is drawn up and initiated over an uninterrupted period that will be specified by the provider.
3.4.9 Human Papilloma Virus (HPV) vaccinations	Females 9 (nine) – 26 (twenty-six) years of age: - 3 (three) vaccinations per beneficiary. - Cervarix/Gardasil shall be funded at Mediscor Reference Price (MRP).
3.4.10 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.
3.4.11 PAP smear:	Preventative benefit is subject to:

HEALTHCARE SERVICES	PULSE1
Tariff codes claimed by pathologists or nappi codes claimed by pharmacies in respect of this benefit are included.	- 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.
3.4.12 Tempo wellness programme: Benefits on the Tempo wellness programme can only be accessed when a beneficiary undergoes a health risk assessment.	**1. Health risk assessments** Beneficiaries 16 (sixteen) years and older - 1 (one) per beneficiary per financial year for beneficiaries 16 (sixteen) years and older. - Biometric screening and lifestyle questionnaire must be completed at Wellness Network pharmacies, onsite at selected Employer Groups or at a Tempo biokineticist. - 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**

HEALTHCARE SERVICES	PULSE1
	- Scheduled throughout the year to encourage and support a healthier lifestyle available to all beneficiaries.
3.4.13 Maternity benefits	Benefits shall be at 100% of Scheme tariff at Network Providers only for the following: Consultations: - 9 (nine) antenatal consultations at either a GP/gynaecologist/midwife. - 1 (one) post-natal consultation at either a GP/gynaecologist/midwife. - 1 (one) lactation consultation with a registered nurse or a lactation specialist. 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.
3.5 OPTOMETRY BENEFITS	Optometry benefits are available per beneficiary every 24 (twenty-four) months from the date of service. Services rendered by Preferred Provider Negotiators (PPN) network optometrists shall be 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

HEALTHCARE SERVICES	PULSE1
	applicable, irrespective if the beneficiary obtained services from a PPN network optometrist or a non–network provider.
	Services may only be obtained from a PPN network optometrist. Benefits shall be as follows: - Consultations at a network provider: 1 (one) per beneficiary at 100% of cost - Spectacle frames or lens enhancements limited to R235 at PPN providers AND - Lenses: Single-vision lenses limited to R210 at PPN providers OR Bifocal lenses limited to R445 at PPN providers - In lieu of glasses Members can opt for contact lenses, limited to R655 at PPN providers
3.6 OUT-OF-HOSPITAL BENEFITS	- No Personal Medical Savings Account. - Full cross subsidisation between Members shall apply without an annual limit. - Benefits may be subject to the annual maxima for the Member with his Dependant(s) and/or as provided for on the benefit. - The Scheme designated health care providers to provide primary healthcare services/day-to-day services to Members through the Bestmed Pulse1 Network. Members may only visit service providers registered on the Pulse1 Network.
3.6.1 GP Consultations	Benefits shall be at 100% of Scheme tariff/cost* for consultations, visits and treatments by GPs registered on the Pulse1 Network for the following:

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	PULSE1
Consultations, visits, diagnostic examinations, injections with General Practitioners (GPs).	- Unlimited medically necessary consultations for basic primary care; and - Specified minor trauma treatment, including stitches, excision and repair, drainage of abscess and limb cast.
3.6.2 Diabetes primary care consultation	Benefits shall be at 100% of Scheme tariff subject to: - Registration with HaloCare; and - 2 (two) primary care consultations at Dis-Chem Pharmacies per financial year.
3.6.3 Out-of-network or casualty visits	Every family qualifies for out-of-network GP and casualty visits: - Benefits shall be at 100% of Scheme tariff/cost* limited to R1 485 per family per year. - All radiology and pathology investigations at the casualty unit, that fall within the primary care radiology and pathology benefit schedule, will be included in this limit. - In the event where the family elects to utilise State facilities for emergency visits, such emergency visits shall be unlimited, in addition to the benefits to which the family is already entitled to. - The Member shall pay for the visit first and then claim back from the Scheme.
3.6.4 Specialist visits	Benefits shall only be considered if referred by a Pulse1 Network GP or a specialist registered on the Pulse Specialist Network or a PPN provider to a specialist on the Pulse Specialist Network and shall be subject to the following: - Pre-approval by the Scheme; - The Scheme treatment protocol and clinical funding guidelines (which includes minor procedures done in specialist rooms and all consumable used); - A co-payment of 30% shall apply if non-formulary medicine is prescribed by the specialist; and - Benefits shall be at 100% of Scheme tariff limited to the following maxima per financial year:

HEALTHCARE SERVICES	PULSE1
	M = R1 500 and M1+= R2 500
3.6.5 Basic and specialised dentistry	Benefits shall be at 100% of Scheme tariff when clinically appropriate, subject to a designated service provider, the Pulse Dental Network approved tariff list and conditions, as well as the following provisions: - 2 (two) consultations for full mouth examination per beneficiary per financial year, subject to the Scheme's list of dental codes; - Extractions if clinically necessary; - Preventative treatment once every 6 (six) months per beneficiary including scaling and polishing and fluoride treatment; - 1 (one) set of dentures per family per 24 (twenty-four) months. Benefits shall be subject to the use of accredited dental laboratories; and - No benefits shall apply for specialised dentistry.
3.6.6 Medical aids, apparatus and appliances, including wheelchairs and hearing aids.	No benefit, except in respect of PMB conditions.
3.6.7 Supplementary services Benefits includes services rendered by physiotherapists, masseurs, chiropractors, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech therapists, biokinetics, private nursing (stoma therapy nursing,	No benefit, except in respect of PMB conditions.

HEALTHCARE SERVICES	PULSE1
obtaining of specimen, observations and administration of medication, immunisations and IV's), psychiatric treatment, psychologists, social workers, homeopaths and acupuncture.	
3.6.8 Wound care benefit Includes dressings and negative pressure wound therapy (NWPT) treatment and nursing services out of hospital.	No benefit, except in respect of PMB conditions.
3.6.9 Basic radiology and pathology	Standard diagnostic imaging and pathology services requested by a Pulse1 Network GP at 100% of Scheme tariff, subject to the following: - Standard diagnostic imaging according to a list of codes approved by the Scheme; and - Basic pathology according to a list of codes approved by the Scheme and subject to the Bestmed Pathology Network.
3.6.10 Specialised Diagnostic Imaging MRI scans, CT scans, PET scans and isotope studies.	No benefit, except in respect of PMB conditions.
3.6.11 Rehabilitation after trauma Benefits for rehabilitation shall be aimed at the recovery of impeded vital functions immediately after trauma such as a stroke or heart attack.	Benefits shall subject to the following: - Pre-authorisation; - Preferred providers or DSPs; - 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.