ANNEXURE B.1 – BENEFIT OPTIONS
2025 BEAT RANGE

1.1 GENERAL CONDITIONS OF THE BENEFIT OPTIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- All hospital and hospital-related benefits shall be subject to Pre-authorisation, major medical expenses which require Pre-authorisation shall be indicated.
- Comprehensive benefits are offered for all pre-authorised services and authorised emergency services rendered during hospitalisation, i.e. from the day of admission up to and including the day of discharge.
- No benefits in a private hospital or day clinic shall be granted by the Scheme or its proxy if Pre-authorisation and an authorisation number have not been obtained:
  - In the event of planned major operations and dental procedures, Members are advised to obtain Pre-authorisation at least 2 (two) weeks in advance to ensure that the Member is aware of applicable benefits, limits, network restrictions, etc., before the event.
  - In an emergency, on the 1st (first) working day after admission to a hospital, or at the first reasonable opportunity as may be determined by the Scheme.
- Late authorisations will be subject to, but not limited to, clinical review, application of rules, benefits, protocols, funding guidelines, as well as the PMB status of the services rendered.
- If Pre-authorisation and an authorisation number have been obtained for treatment in a private hospital or day clinic but the treatment cost exceeds the authorised benefits, only the benefits of the authorised treatment cost shall be granted and the Member shall be liable for payment of the excess to the service provider, unless if the excess costs were as a direct result of treatment received and necessary for the beneficiary and authorisation could not be obtained in time.
- 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	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
- The Scheme's list of Hospital Network DSP (contracted private hospitals and contracted State facilities) and designated and preferred service providers, available on the Scheme's website or via the Contact Centre, shall be applicable to benefits. - Co-payments: ▪ A co-payment of a specified amount indicated in Rule 1.2.28 per hospital admission shall apply on the following: o Arthroscopic procedures o Back and neck surgery o Functional nasal and sinus procedures o Laparoscopic procedures o Colonoscopies o Cystoscopies o Gastroscopies o Hysteroscopies o Sigmoidoscopies o Extraction of wisdom teeth ▪ A co-payment of a specified amount indicated in Rule 1.2.16 per scan shall apply for MRI and CT scans conducted whether in or out of hospital. ▪ A co-payment of a specified amount indicated in Rule 1.2.27 shall be incurred per event if a day procedure is done in an acute hospital that is not a day hospital. If a DSP is used and the DSP does not work in a day hospital, the procedure shall be paid in full if it is done in an acute hospital, if it is arranged with the Scheme before the time. ▪ A co-payment of a specified amount indicated in Rule 1.2.28 shall apply on the Beat Network benefit options for the voluntary use of a non-designated Hospital Network, i.e. where a Member or his Dependant(s) voluntarily choose not to make use of a hospital forming part of the Hospital Network.					

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.2.1 Hospitalisation: Pre-authorisation must be obtained for accommodation (hospital stay) in a general ward, intensive-care and high-care unit, theatre and material.	Benefits shall be at 100% of Scheme tariff/cost*. DSP Network applies.				
1.2.2 Take-home medicine: Medicine supplied by the hospital when a patient is discharged.	Medicine prescribed by the treating provider for a patient discharged from hospital, relating to the admission, to take home will be paid at 100% of Scheme tariff/cost* for a maximum supply of 7 (seven) days provided that: - the medicine is claimed as part of the hospital account; or - the medicine claim shall be limited to R150 if claimed from a retail pharmacy on the date of discharge. No benefit shall be awarded if medicine is not claimed on the date of discharge from hospital.				
1.2.3 Biological medicine during hospitalisation Biological medicine is a substance that is made from a living organism or	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and limited to R11 610 per	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and limited to R17 414 per	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and limited to R23 218 per family per financial year.		Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and limited to R29 022 per

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
its products and is used in the prevention, diagnosis, or treatment of acute and chronic diseases.	family per financial year.	family per financial year.			family per financial year.
1.2.4 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 in hospital including inpatient electro-convulsive therapy and inpatient psychotherapy, OR 15 (fifteen) contact sessions for out-patient psychotherapy per beneficiary per financial year, Pre-authorisation and DSP Network.				
1.2.5 Treatment of chemical and substance abuse	Benefits shall be limited to the treatment of PMB conditions and subject to the following: - Pre-authorisation; - DSP Network; and - The length of stay shall be limited to 21 (twenty-one) days for in-hospital management per beneficiary per financial year.				
1.2.6 Consultations and procedures: Consultations, visits, operations, surgical procedures and anaesthetics during	Claims submitted by General Practitioners (GPs) and specialists for treatment during hospitalisation shall be at 100% of Scheme tariff/cost*. DSP Network applies for the Beat Network and Beat3 Plus benefit options.				

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
hospitalisation and/or admission to day clinics.					
1.2.7 Organ transplants (in and/or out of hospital): Pre-authorisation must be obtained.	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules, and shall be paid at cost as per PMB regulations.				
1.2.8 Stem cell transplants (in and/or out of hospital): Pre-authorisation must be obtained.	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules, and shall be paid at cost as per PMB regulations. The donor search and related costs shall be limited to the Scheme approved amount per financial year.				
1.2.9 Blood transfusion	Blood, operators' fees, transport charges and apparatus payable at 100% Scheme tariff/cost*.				
1.2.10 Dental / Oral / 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.				
1.2.10.1 Dental and oral surgery (in and/or out of hospital)	No benefits, except for the treatment of certain PMB conditions the	Qualifying PMB procedures only at DSP day hospitals.	100% at Scheme tariff limited to R9 768 per family per financial year for the following procedures performed either in or out of hospital:		100% at Scheme tariff limited to R12 210 per family per financial year

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
	standard of care in the State sector which shall be paid at cost at DSP day hospitals.	PULP procedures, extractions and restorations in DSP day hospital, only for beneficiaries of ages 0 (zero) until 7 (seven) years and disabled beneficiaries, shall be limited to R6 350 per family. Dental surgical procedures for beneficiaries over 7 (seven) years shall be paid from the PMSA at 100% Scheme tariff for the following procedures performed in the doctor's rooms only:	- Surgical extractions of teeth / roots / impactions / failed implants – refer to Rule 1.2.28 for an applicable procedure-specific co-payment; - Surgical drainage of dental abscess; - Alveolectomy / alveolotomy (preparatory surgery for dental prosthesis); - Root canal related surgery.		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	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
		- Surgical extractions of teeth / roots / impactions / failed implants – refer to Rule 1.2.28 for an applicable procedure-specific co-payment; - Surgical drainage of dental abscess; - Alveolectomy / alveolotomy (preparatory surgery for dental prosthesis); - Root canal related surgery.			- Pre-prosthetic (preparatory to dental prosthetics) surgery; - Orthodontic related / orthognathic surgery.
1.2.10.2 Major maxillo-facial surgery, strictly related to certain conditions	No benefits, except for the treatment of PMB conditions as per standard of care in the State sector which shall be paid at cost at DSP day hospitals.		100% of Scheme tariff limited to R15 658 per family per financial year, strictly for the following conditions:		100% of Scheme tariff limited to R15 945 per family per financial year,

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
			- 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.		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,

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

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.2.11.1 Prosthesis – Internal Prosthesis surgically implanted during operations for the replacement of parts of the human body for functional medical reasons, including delivery systems and related items.	Benefits shall not be pro-rated and shall be paid at 100% of Scheme tariff/cost* limited to the overall limit of R95 377 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular R54 915 - Pacemaker (single and dual chambers) R51 998 and at DSP prices - Endovascular and catheter base procedures are subject to the Vascular prosthesis sub-limit and at DSP prices - Spinal including artificial disk (single level based) R38 068 - Drug-eluting stents are subject to the Vascular prosthesis sub-limit and at DSP prices - Mesh R13 360 - Gynaecology / Urology R10 917 - Lens implants R8 330 a lens per eye - Functional prosthesis (items used to replace or augment an impaired bodily function) R34 047		Benefits shall not be pro-rated and shall be paid at 100% of Scheme tariff/cost* limited to the overall limit of R96 384 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular R65 898 - Pacemaker (single and dual chambers) R51 998 and at DSP prices - Endovascular and catheter base procedures are subject to the Vascular prosthesis sub-limit and at DSP prices - Spinal including artificial disk (single level based) R38 208 - Drug-eluting stents are subject to the Vascular prosthesis sub-limit and at DSP prices - Mesh R13 429 - Gynaecology / Urology R11 091 - Lens implants R8 330 a lens per eye - Functional prosthesis (items used to replace or augment an impaired bodily function) R35 146		Benefits shall not be pro-rated and shall be paid at 100% of Scheme tariff/cost* limited to the overall limit of R117 652 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular R71 390 - Pacemaker (single and dual chambers) R68 086 and at DSP prices - Endovascular and catheter base procedures are subject to the Vascular

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					prosthesis sub-limit and at DSP prices - Spinal including artificial disk (single level based) R40 652 - Drug-eluting stents R22 839 and at DSP prices - Mesh R15 083 - Gynaecology / Urology R11 061 - Lens implants R8 618 a lens per eye - Functional prosthesis (items used to replace or augment an impaired bodily function) R37 342
1.2.11.2 Prosthesis – External: Prosthesis used after operations for the	No benefit, except in respect of PMB conditions.				Limited to R28 297 per family per financial year: - 2 (two) quotations may be required;

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
replacement of parts of the human body for functional medical reasons, including delivery systems and related items. A list of prosthesis covered can be requested from the Scheme.					- 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

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					appliances benefit indicated in Rule 1.7.3.
1.2.11.3 Exclusions on joint replacement surgery for non-PMB conditions	No benefit for joint replacement surgery, except for PMBs, subject to the following prosthesis limits, that form part of the Prosthesis – Internal overall limit, at 100% contracted fees: - Hip replacement and other major joints R40 075 - Knee replacement R49 413 - Other minor joints R15 371		No benefit for joint replacement surgery, except for PMBs, subject to the following prosthesis limits, that form part of the Prosthesis – Internal overall limit, at 100% contracted fees: - Hip replacement and other major joints R40 364 - Knee replacement R49 944 - Other minor joints R15 371		No benefit for joint replacement surgery, except for PMBs, subject to the following prosthesis limits, that form part of the Prosthesis – Internal overall limit, at 100% contracted fees: - Hip replacement and other major joints R41 800 - Knee replacement R55 532 - Other minor joints R17 063
1.2.12 Breast surgery for cancer	Treatment of the unaffected (non-cancerous) breast shall be limited to PMB provisions and is subject to Pre-authorisation and funding guidelines.				

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.2.13 Orthopaedic and medical appliances during hospitalisation: Appliances directly related to the hospital admission and/or procedure.	Benefits shall be at 100% of Scheme tariff/cost* limited to R15 000 per family per financial year for medically necessary appliances subject to PMB level of care for back, leg, arm and neck support, crutches, surgical footwear and elastic stockings directly related to the admission and provided before discharge from hospital.				
1.2.14 Pathology during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*.				
1.2.15 Basic radiology during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*.				
1.2.16 Specialised diagnostic imaging (in and/or out of hospital): MRI scans, CT scans and nuclear/isotope studies. PET scans are only included as indicated per the benefit option.	Benefits shall be at 100% of Scheme tariff/cost* limited to a combined in and out of hospital benefit of R20 000 per family per financial year, subject to the following: - A co-payment of R2 600 per scan for MRI scans,	Benefits shall be at 100% of Scheme tariff/cost* limited to a combined in and out of hospital benefit of R22 000 per family per financial year, subject to the following: - A co-payment of R2 100 per scan for MRI	Benefits shall be at 100% of Scheme tariff/cost* limited to a combined in and out of hospital benefit of R32 000 per family per financial year, subject to the following:	Benefits shall be at 100% of Scheme tariff/cost* limited to a combined in and out of hospital benefit of R35 000 per family per financial year, subject to the following:	Benefits shall be at 100% of Scheme tariff/cost* limited to a combined in and out of hospital benefit of R40 000 per family per financial year, subject to the following:

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
Pre-authorisation must be obtained for all specialised diagnostic imaging benefits.	CT scans and nuclear/isotope studies, except for a PMB condition. PET scans are excluded, except for a PMB condition.	scans, CT scans and nuclear/isotope studies, except for a PMB condition. PET scans are excluded, except for a PMB condition.	- A co-payment of R2 000 per scan for MRI scans, CT scans and nuclear/isotope studies, except for a PMB condition. PET scans are excluded, except for a PMB condition.	- A co-payment of R2 000 per scan for MRI scans, CT scans and nuclear/isotope studies, except for a PMB condition. PET scans are excluded, except for a PMB condition.	- A co-payment of R2 000 per scan for MRI scans, CT scans and nuclear/isotope studies, except for a PMB condition. PET scans are not subject to the abovementioned benefit limit and shall be limited to 1 (one) scan per beneficiary per financial year.
1.2.17 Oncology benefits (in or out of hospital)	Oncology programme benefits at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.				
1.2.18 Peritoneal dialysis and	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.				

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
haemodialysis (in or out of hospital)					
1.2.19 HIV/AIDS benefits (in or out of hospital)	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.				
1.2.20 Confinements	Benefits shall be at 100% of Scheme tariff/cost*, even if the baby dies before registration, for the following: - Medical practitioners; - Nursing home and hospital fees in accordance with the provisions of the "Hospitalisation" benefit; - Midwife assisted births in an Active Hospital Birth Unit or home confinement by a midwife. Transport fees, hospital facility fees, renting of a birth pool, medical disposables or medication, antenatal consultations, doulas and breastfeeding support shall be excluded from benefits if these are not PMB level of care; and - Midwife assisted births at a private midwife birth house. Transport fees, renting of a birth pool, antenatal consultations, doulas and breastfeeding supports shall be excluded from benefits if these are not PMB level of care.				
1.2.21 Refractive surgery and other procedures done to improve or stabilise vision, except for cataracts	No benefit, except in respect of PMB conditions.		Benefits shall be at 100% of Scheme tariff limited to R10 055 per eye, subject to Pre-authorisation and protocols.		Benefits shall be at 100% of Scheme tariff limited to R11 349 per eye, subject to Pre-authorisation and protocols.

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.2.22 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, osteopaths, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech therapists, biokinetics, stoma therapist and social workers.				
1.2.23 Alternatives to hospitalisation (i.e. procedures done in the doctor's rooms)	Benefits shall be at 100% of Scheme tariff subject to: - Pre-authorisation; - Step-down facilities approved by the Scheme; and - Services must be rendered by registered private nurses and hospices.				
1.2.24 Advance illness benefit	Benefits shall be at 100% of Scheme tariff/cost* limited to R69 654 per beneficiary per financial year, subject to Pre-authorisation.				Benefits shall be at 100% of Scheme tariff/cost* limited to R104 482 per beneficiary per financial year, subject to Pre-authorisation.
1.2.25 Ambulance and emergency evacuation services	Benefits shall be subject to: - Provisions of benefits by Netcare 911, as the Scheme's capitated preferred provider for ambulance services. - Benefits shall only be payable if the evacuation service was involuntarily requested and delivered by a service provider other than the preferred provider: Provided that services in respect of PMB conditions shall be payable at cost, without deductibles or the				

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
	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.				
1.2.26 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 preferred provider for international travel insurance. - Cover for leisure and business travel for emergency medical and related expenses: ▪ Leisure travel is limited to 90 (ninety) days and R1 million cover for travelling to the United States of America (USA) for a family i.e. Member and Dependant(s). All other countries are covered up to 90 (ninety) days for R5 million for a family i.e. Member and Dependant(s). ▪ Business travel is limited to 60 (sixty) days and R1 million cover for travelling to the USA for a family i.e. Member and Dependant(s). All other countries are covered up to 60 (sixty) days for R5 million for a family i.e. Member and Dependant(s). - A Member must give at least 48 (forty-eight) hours advance notice when he and/or his Dependant(s) are 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.				

<table>
<tr><th>HEALTHCARE SERVICES</th><th>BEAT1 AND BEAT1 NETWORK</th><th>BEAT2 AND BEAT2 NETWORK</th><th>BEAT3 AND BEAT3 NETWORK</th><th>BEAT3 PLUS</th><th>BEAT4</th></tr>
<tr><td>1.2.27 Day procedures at a day hospital facility</td><td colspan="5">Day procedures at a day hospital or day clinic facility shall be funded at 100% of Scheme tariff/cost*, subject to:
- Pre-authorisation;
- Protocols and funding guidelines; and
- DSPs and preferred providers

A co-payment of R2 746 shall be incurred per event if a day procedure is done in an acute hospital that is not a day hospital. If a DSP is used and the DSP does not work in a day hospital, the procedure shall be paid in full if it is done in an acute hospital, if it is arranged with the Scheme before the time.</td></tr>
<tr><td rowspan="2">1.2.28 Co-payments</td><td colspan="4">Voluntary use of a non-designated Hospital Network co-payment:

A co-payment of R14 364 shall apply on the Beat1 Network, Beat2 Network and Beat3 Network benefit options for the voluntary use of a non-designated Hospital Network, i.e. where a Member or his Dependant(s) voluntarily choose not to make use of a hospital forming part of the Hospital Network.</td><td>Not Applicable</td></tr>
<tr><td colspan="5">Procedure-specific co-payments

The co-payments indicated below shall apply for the listed procedures, except with respect to a PMB condition:
- Arthroscopic procedures - R3 660
- Back and neck surgery - R3 660
- Functional nasal and sinus procedures - R2 000</td></tr>
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* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
	- Laparoscopic procedures - R3 660 - Colonoscopies - R2 000 - Cystoscopies - R2 000 - Gastroscopies - R2 000 - Hysteroscopies - R2 000 - Sigmoidoscopies - R2 000 - Extraction of wisdom teeth - R2 500 A co-payment of R2 746 shall be incurred per event if a day procedure is done in an acute hospital that is not a day hospital. If a DSP is used and the DSP does not work in a day hospital, the procedure shall be paid in full if it is done in an acute hospital, if it is arranged with the Scheme before the time.				
1.3 MEDICINE BENEFITS Benefits for chronic, high-cost medicine, acute and over-the-counter (OTC) medicine shall be subject to: - Prior application and approval by the Scheme where indicated. - The Scheme treatment protocols and clinical funding guidelines. Motivations and reports by appropriate medical practitioners may be requested by the Scheme. - The Scheme's formulary (medicine list), where applicable. - Where medicines have generic alternatives registered with the South African Health Products Regulatory Authority (SAHPRA), the Scheme will reimburse those medicines up to the MRP for that active ingredient.					

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
- 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 shall apply for the conditions indicated with double asterisks (**) where provision is not made in the Diagnosis and Treatment Pairs constituting the PMB package as listed in the Medical Schemes Act. - Approved PMB, CDL and non-CDL chronic medicine costs shall be paid from the non-CDL limit first. Thereafter, only approved PMB and CDL chronic medicine costs shall be paid by the Scheme. Approved treatment for organ transplant, chronic renal failure, multiple sclerosis and haemophilia will be paid directly from Scheme risk and not non-CDL limit. - Over-the-counter (OTC) medicine benefits are not applicable to the Beat1 and Beat1 Network benefit options.					
1.3.1 Chronic medicine not listed on the chronic disease list ("non-CDL medicine")	No benefit	Medicine on the formulary shall be covered at 80% of Scheme tariff with a 20% co-payment and non-formulary medicine shall be covered at 70% of Scheme tariff with a 30% co-payment. Payment shall be at Scheme tariff limited to M = R4 166 and M1+ = R8 475 per financial year, for the following 5 (five) non-CDL conditions:		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.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
			- Acne - Allergic rhinitis - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Eczema - 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.		Payment shall be limited to M = R9 150 and M1+ = R18 301 per financial year, for the following 9 (nine) non-CDL conditions: - Acne - Allergic rhinitis - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Eczema - Gastro Oesophageal Reflux Disease (GORD)** - Gout Prophylaxis** - Major Depression** shall be covered as a

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					life-sustaining condition once the non-CDL benefit limit has been depleted - Migraine prophylaxis - Obsessive Compulsive Disorder Subject to: - Prior application and approval by the Scheme and benefits shall be from the date on which the application was received by the Scheme or its proxy.
1.3.2 Medicine for PMB conditions including the conditions listed	Benefits shall be at 100% of Scheme tariff/cost*, subject to: - Prior application and approval by the Scheme. - A co-payment of 30% shall apply for the voluntary use of non-formulary medicine.				Benefits shall be at 100% of Scheme tariff/cost*, subject to:

* As per the provisions of Rule 1.1.8.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
on the chronic disease list (CDL)					- Prior application and approval by the Scheme. - A co-payment of 20% shall apply for the voluntary use of non-formulary medicine.
1.3.3 Biologicals medicine out of hospital: Biological medicine is a substance that is made from a living organism or its products and is used in the prevention, diagnosis, or treatment of acute and chronic diseases	Scheme pre-approval is required and out of hospital benefits are limited to the treatment of certain PMB conditions, as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations, shall be paid at cost.				
1.3.4 Other high-cost medicine out of hospital	Scheme pre-approval is required and out of hospital benefits are limited to the treatment of certain PMB conditions, as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations, shall be paid at cost.				

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.3.5 Acute medicine	No benefit	Benefits shall be at 100% of Scheme tariff from the PMSA for: - Medicine, excluding medicine referred to in Annexure C2 of the registered Rules, prescribed out of a hospital by a medical practitioner, a contracted Pharmacist Primary Care Drug Therapy (PCDT) pharmacist, or dentist or a person authorised thereto by law. - Registered homeopathic remedies, injections and herbal remedies.			Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall subject to the overall day-to-day limit and the following maxima per financial year: M = R3 491 and M1+ = R7 052 Benefits shall be for: - Medicine, excluding medicine referred to in Annexure C2 of the registered Rules, prescribed out of a hospital by a medical

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					practitioner, a contracted Pharmacist Primary Care Drug Therapy (PCDT) pharmacist, dentist or a person authorised thereto by law. - Registered homeopathic remedies with nappi code(s). - Benefits for homeopathic remedies, injections and herbal remedies without nappi code(s) shall be paid from the Vested Medical Savings Account.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.3.6 Over-the-counter (OTC) medicine The member may choose how to access OTC medicine benefits: 1. The OTC medicine benefit with a set limit on the PMSA. OR 2. The OTC medicine benefit without a set limit on the PMSA to accumulate a self-payment gap.	No benefit	Shall be paid at 100% at Scheme tariff from the PMSA. Benefit includes, but not limited to, purchases of sunscreen, vitamins and minerals with nappi codes on the Scheme's formulary.			1. The OTC medicine benefit up to the limit of R1 161 per family per financial year, paid at 100% of Scheme tariff from the PMSA. Benefit includes, but not limited to, purchases of sunscreen, vitamins and minerals with nappi codes on the Scheme's formulary. 1.1 Once the set limit has been reached, the member may access further OTC medicine benefits through the Vested

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					Medical Savings Account where purchases shall be paid at 100% Scheme tariff. OR 2. OTC medicine benefit without a limit on the PMSA to accumulate a self-payment gap once the limit of R1 161. has been reached. 2.1 The threshold will be determined by the amount allocated to the annual PMSA at the

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					beginning of the year, or pro-rated if the Member joins after January, from which OTC medicine purchases, in excess of the aforementioned set limit, will accumulate to a self-payment gap. 2.2 Once a self-payment gap has accumulated, the day-to-day health care services, as indicated in Rule 1.7 of this Annexure, will

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					contribute towards the payment of the self-payment gap, thus reducing and ultimately closing the self-payment gap. The Member will only be able to access the Scheme's day-to-day benefits after contributing to the full amount of the self-payment gap. 2.3 The cost or Scheme tariff for services, whichever is lower, shall be used in the calculation of the contribution towards

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					the self-payment gap: Non-contributing services or items shall not be taken into account in this calculation. 2.4 Where the annual PMSA is depleted, the Member will be liable for day-to-day claims (i.e. pay out of his own pocket) until he fully contributes to the self-payment gap amount. 2.5 The Member must continue to submit

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					claims to the Scheme, even when the Member is in the self-payment gap, as this will inform the Scheme when the Member has fully contributed to the self-payment gap and consequently qualifies for the Scheme's day-to-day benefits. The claims must be submitted to the Scheme not later than the last day of the 4th (fourth) month following the month in which the

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					relevant health service was rendered.
1.4 PREVENTATIVE CARE AND WELLNESS BENEFITS	Benefits shall be at 100% of Scheme tariff and DSPs or preferred providers.				
1.4.1 Influenza vaccine	1 (one) vaccine per beneficiary per financial year.				
1.4.2 Pneumonia programme	Children under 2 (two) years of age: - As per the schedule of the Department of Health. Adult group: - Twice in a lifetime, with a booster if beneficiary is above 65 (sixty-five) years of age. - The Scheme in accordance with its protocol, will identify certain high-risk individuals who will be advised to be immunised.				
1.4.3 Travel vaccinations	No benefit	Bestmed provides cover for certain mandatory travel vaccines for typhoid, yellow fever, tetanus, meningitis, hepatitis and cholera from Scheme risk benefits.			
1.4.4 Baby growth and development assessments	Children from 0 (zero) up to 2 (two) years of age: - 3 (three) assessments per year. - Assessments must be conducted at a pharmacy clinic or by a registered nurse.				
1.4.5 Paediatric immunisations	No benefit	Paediatric vaccines according to the State recommended programme for babies and children.			

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.4.6 Female contraceptives	Applicable to all females of childbearing age: - Quantity and frequency depending on product up to the maximum of R2 000 per beneficiary per financial year, which includes all items classified in the category of female contraceptives. - Intrauterine device (IUD) once every 5 (five) years.	Applicable to all females of childbearing age: - Quantity and frequency depending on product up to the maximum of R2 200 per beneficiary per financial year, which includes all items classified in the category of female contraceptives. - Intrauterine device (IUD) – insertion (consultation and procedure) of the device if done by a gynaecologist or GP once every 5 (five) years.	Applicable to all females of childbearing age: - Quantity and frequency depending on product up to the maximum of R2 400 per beneficiary per financial year, which includes all items classified in the category of female contraceptives. - Intrauterine device (IUD) – insertion (consultation and procedure) of the device if done by a gynaecologist or GP once every 5 (five) years.		Applicable to all females of childbearing age: - Quantity and frequency depending on product up to the maximum of R2 678 per beneficiary per financial year, which includes all items classified in the category of female contraceptives. - Intrauterine device (IUD) – insertion (consultation and procedure) of the device if done by a gynaecologist or GP once every 5 (five) years.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.4.7 Preventative dentistry	No benefit	Benefits are applicable per beneficiary: 1. **General full mouth examination by a general dentist (incl. gloves and use of sterile equipment for this visit):** - For beneficiaries under 12 (twelve) years - twice per financial year. - For beneficiaries 12 (twelve) years and older- once per financial year. 2. **Full mouth intra-oral radiographs:** All ages, once every 36 (thirty-six) months. 3. **Intra-oral radiograph:** All ages, 2 (two) x photos per financial year. 4. **Scaling and/or polishing:** All ages, every 6 (six) months from the date of service. 5. **Fluoride treatment:** All ages, every 6 (six) months from the date of service. 6. **Fissure sealing:** Beneficiaries up to and including 21 (twenty-one) years, the frequency will be in accordance with accepted protocol. 7. **Space maintainers:** During primary and mixed denture stage, once per space.			
1.4.8 Mammogram	Females 40 (forty) years and older - once every 24 (twenty-four) months.				

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.4.9 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).				
1.4.10 Prostate Specific Antigen (PSA) test: Tariff codes claimed by pathologists or nappi codes claimed by pharmacies in respect of this benefit are included.	No benefit	Males 50 (fifty) years and older: - Once every 24 (twenty-four) months per beneficiary. - To be done at urologist or GP. Urologist or GP consultation paid from the available consultation benefit.			
1.4.11 PAP smear: Tariff codes claimed by pathologists 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 GP. - Consultation fee paid from the available PMSA on the Beat2, Beat2 Network, Beat3, Beat3 Network and Beat3 Plus benefit options. The Member shall be liable for the consultation costs on the Beat1 and Beat1 Network benefit options.				Preventative benefit is subject to: - Females 18 (eighteen) years and older. - Once every 24 (twenty-four) months per beneficiary for PAP smear tariff code 4566 or 4559.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					- To be done at a gynaecologist or GP. - Consultation fee paid from the Preventative Care benefit.
1.4.12 Tempo programme: Benefits on the Tempo wellness programme can only be accessed when a beneficiary undergoes a lifestyle screening .	**1. Tempo Lifestyle Screening** Beneficiaries 16 (sixteen) years and older - 1 (one) per beneficiary per financial year. - This includes a biometric screening and lifestyle questionnaire that must be completed at Network pharmacy clinics, or onsite at selected Employer groups, or at an accredited Tempo biokineticist, or Tempo GP. Only participating Employer groups which allow onsite screening and nurses onsite, or allow the Scheme to conduct the lifestyle screening at the workplace. Alternatively, Members can obtain the services from their pharmacy clinics or accredited Tempo biokineticist or nurses. - Beneficiaries must complete a lifestyle screening in order to unlock the biokineticist and dietician consultations that form part of the Tempo programme benefits. **2. Fitness and nutritional interventions available to beneficiaries 16 (sixteen) years and older** Fitness - 1 (one) fitness test at a Tempo biokineticist conducted in person; and - 1 (one) follow-up in person or virtual consultation at a Tempo biokineticist to obtain a personalised fitness/exercise plan.				

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
	Nutrition - 1 (one) nutritional assessment at a Tempo dietician; and - 1 (one) follow-up in person or virtual consultation at a Tempo dietician to obtain a personalised diet plan.				
1.5 MATERNITY BENEFITS	Benefits shall be at 100% of Scheme tariff per beneficiary per financial year, subject to the following: Consultations: - 6 (six) antenatal consultations at either a GP/gynaecologist/midwife. Ultrasounds: - 1 (one) 2D ultrasound scan at 1st (first) trimester (between 10 (ten) to 12 (twelve) weeks) at a gynaecologist/GP/radiologist. - 1 (one) 2D ultrasound scan at 2nd (second) trimester (between 20 (twenty) to 24 (twenty-four) weeks) at a gynaecologist/GP/radiologist.		Benefits shall be at 100% of Scheme tariff 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. 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 R139 per claim, once a month, for a maximum of 9 (nine) months.		

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
1.6 OPTOMETRY BENEFITS	No benefit	Benefits shall be paid from the PMSA.		Optometry benefits are available per beneficiary every 24 (twenty-four) months from the date of service. Services rendered by the designated optical network, Preferred Provider Negotiators (PPN), optometrists shall be payable at 100% of contracted fee. Services rendered by a non-network provider shall be subject to the maxima indicated.	
				Benefits from a PPN optometrist shall be as follows: - Consultations: 1 (one) per beneficiary at 100% of cost. - Spectacle frames or lens enhancements limited to R945 AND	Benefits from a PPN optometrist shall be as follows: - Consultations: 1 (one) per beneficiary at 100% of cost. - Spectacle frames or lens enhancements limited to R1 210 AND

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
				- Lenses: standard lenses (i.e. single vision or bifocal or multifocal lenses) at 100% of cost OR - Contact lenses limited to R1 710 Benefits from a non-network provider shall be as follows: - Consultations: 1 (one) per beneficiary limited to R400 - Spectacle frames or lens enhancements limited to R709 AND - Lenses:	- Lenses: standard lenses (i.e. single vision or bifocal or multifocal lenses) at 100% of cost OR - Contact lenses limited to R2 025 Benefits from a non-network provider shall be as follows: - Consultations: 1 (one) per beneficiary limited to R400 - Spectacle frames or lens enhancements limited to R908 AND - Lenses:

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
				Single-vision lenses limited to R215 OR Bifocal lenses limited to R460 OR Multifocal lenses limited to R1 040 (consisting of R810 per base lens plus R230 per branded lens add-on) - In lieu of glasses Members can opt for contact lenses, limited to R1 710	Single-vision lenses limited to R215 OR Bifocal lenses limited to R460 OR Multifocal lenses limited to R1 040 (consisting of R810 per base lens plus R230 per branded lens add-on) - In lieu of glasses Members can opt for contact lenses, limited to R2 025
1.7 OUT-OF-HOSPITAL BENEFITS	No Personal Medical Savings Account (PMSA). Full cross subsidisation between Members shall	Refer to Annexure B.4 for the conditions of payment from the Personal Medical Savings Account (PMSA) and the Vested Medical Savings Account. Full cross subsidisation between Members shall apply without an annual limit, except in relation to the PMSA.			- Refer to Annexure B.4 for the conditions of payment from the Personal Medical Savings Account

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
	apply without an annual limit.				(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.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					- The following combined overall limit for day-to-day benefits shall apply per financial year: M = R15 513 and M1+= R31 025
1.7.1 GP, nurse and specialist consultations Consultations, visits, diagnostic examinations, injections and emergency unit visits (where a procedure room was used) with General Practitioners (GPs), contracted Nursing Clinical	Not applicable	Benefits shall be at 100% of Scheme tariff from the PMSA.			Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be subject to the overall day-to-day limit and the following maxima per financial year:

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
Services, contracted Pharmacist Primary Care Drug Therapy (PCDT) pharmacists, Specialists, Homeopaths and Herbalists.					M = R3 951 and M1+ = R7 037
1.7.2 Basic and specialised dentistry Includes basic and specialised dentistry not defined under Preventative dentistry benefits or Dental / Oral / Jaw surgical benefits.	Not applicable	Benefits shall be at 100% of Scheme tariff from the PMSA, subject to the following: - Basic dentistry shall be paid from the Preventative dentistry benefit or the PMSA. - Specialised dentistry which includes the following shall be paid from the PMSA: - Prosthodontics services (crowns, bridges, inlays, veneers and dentures); - Periodontics services (gum diseases); - Orthodontic services (correction of irregular teeth by means of braces, retainers or similar) are subject to Pre-authorisation; and - Dental implants, implant costs and all laboratory costs related to the aforementioned services.			Benefits shall be at 100% of Scheme tariff from the PMSA, subject to the following: - Basic dentistry shall be paid from the Preventative dentistry or PMSA. - Specialised dentistry benefits which include: - Prosthodontics services (crowns, bridges, inlays,

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					veneers and dentures); - Periodontics services (gum diseases); - Orthodontic services (correction of irregular teeth by means of braces, retainers or similar) are subject to Pre-authorisation; and - Dental implants, implant costs and all laboratory costs related to the aforementioned services.

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					Once the funds in the PMSA have been depleted, benefits shall be subject to the overall day-to-day limit and the following maxima per financial year: M = R6 835 and M1+ = R13 728
1.7.3 Medical aids, apparatus and appliances including wheelchairs and hearing aids. Pre-authorisation must be obtained for all hearing aid devices fitted and the following	Not applicable	Benefits shall be at 100% of Scheme tariff from the PMSA, for the following: - Hearing aid - Pre-authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 1.7.3; - Back, leg, arm and neck support; - Wheelchairs; - Surgical footwear; - Crutches; - Elastic stockings; - Repair work on hearing aids, artificial limbs, wheelchairs, etc.; and			Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be subject to the overall day-to-day limit and R13 934 per family per financial year for appliances that shall

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
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		- Stoma products, Oxygen and Diabetic supplies for non-PMB conditions.			include any of the items listed below: - Back, leg, arm and neck support; - Wheelchairs; - Surgical footwear; - Crutches; - Elastic stockings; - Repair work on artificial limbs, wheelchairs, etc.; and - Stoma products, Oxygen and Diabetic supplies for non-PMB conditions.
					Hearing aids and/or repair at 100% of Scheme tariff limited to R12 770 per family

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
Scheme, the product serial number(s) of the hearing aid device(s).					every 24 (twenty-four) months. Pre-authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 1.7.3.
1.7.4 Supplementary services Benefits includes services rendered by physiotherapists, masseurs, chiropractors, osteopaths, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech	No benefit	Benefits shall be at 100% of Scheme tariff from the PMSA.		Benefits shall be at 100% of Scheme tariff and be limited to R2 092 per family per financial year subject to the use of DSPs. Once the set limit has been reached, the member may access further benefits from the	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:

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
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 at 100% Scheme tariff.	M = R6 033 and M1+ = R12 253
1.7.5 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 and be limited to R4 267 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

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
					R6 033 per family per financial year.
1.7.6 Basic radiology and pathology	No benefit	Benefits shall be at 100% of Scheme tariff from the PMSA.			Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R3 950 and M1+ = R8 044
1.7.7 MHC Back and Neck Programme	Benefits shall be payable at 100% of contracted fee and are applicable to all ages – subject to Pre-authorisation: - Applicable to beneficiaries with serious back or neck problems that may require surgery and use of this programme is in lieu of surgery. - Preferred providers, i.e. DBC or Workability clinics. - The Scheme may identify appropriate participants for evaluation at a DBC or Workability clinic.				

HEALTHCARE SERVICES	BEAT1 AND BEAT1 NETWORK	BEAT2 AND BEAT2 NETWORK	BEAT3 AND BEAT3 NETWORK	BEAT3 PLUS	BEAT4
	Based on the first assessment, a rehabilitation treatment plan is drawn up and initiated over an uninterrupted period that will be specified by the provider.				
1.7.8 Rehabilitation after trauma Benefits for rehabilitation shall be aimed at the recovery of impeded vital functions immediately 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.				Benefits shall be at 100% of Scheme tariff.