ANNEXURE B.2 – BENEFIT OPTIONS
2025 PACE RANGE

2.1 GENERAL CONDITIONS OF THE BENEFIT OPTIONS

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

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

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

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

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

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

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

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

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

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

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

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

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4

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

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

<table>
<tr><th>HEALTHCARE SERVICES</th><th>PACE1</th><th>PACE2</th><th>PACE3</th><th>PACE4</th></tr>
<tr><td colspan="5">- Co-payments:
▪ A co-payment of a specified amount indicated in Rule 2.2.16 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 2.2.28 shall be incurred per event if a day procedure is done in an acute hospital that is not a day hospital. If a DSP is used and the DSP does not work in a day hospital, the procedure shall be paid in full if it is done in an acute hospital, if it is arranged with the Scheme before the time.</td></tr>
<tr><td>2.2.1 Hospitalisation:
Pre-authorisation must be obtained for accommodation (hospital stay) in a general ward, intensive-care and high-care unit, theatre and material.</td><td colspan="4">Benefits shall be at 100% of Scheme tariff/cost*.</td></tr>
<tr><td>2.2.2 Take-home medicine:
Medicine supplied by the hospital when a patient is discharged.</td><td colspan="4">Medicine prescribed by the treating provider for a patient discharged from hospital, relating to the admission, to take home will be paid at 100% of Scheme tariff/cost* for a maximum supply of 7 (seven) days provided that:
- the medicine is claimed as part of the hospital account; or
- the medicine shall be limited to R200 if claimed from a retail pharmacy if claimed on the date of discharge.

No benefit shall be awarded if medicine is not claimed on the date of discharge from hospital.</td></tr>
<tr><td>2.2.3 Biological medicine during hospitalisation
Biological medicine is a substance that is made from a living organism</td><td>Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and</td><td colspan="3">Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and the biologicals and other high-cost medicine benefit limit indicated on Rule 2.3.3.</td></tr>
</table>

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
or its products and is used in the prevention, diagnosis, or treatment of acute and chronic diseases.	limited to R34 828 per family per financial year.			
2.2.4 Treatment in mental health clinics	Benefits shall be at 100% of Scheme tariff/cost*, subject to the length of stay limited to 21 (twenty-one) days per beneficiary per financial year in hospital including inpatient electro-convulsive therapy and inpatient psychotherapy, OR 15 (fifteen) contact sessions for out-patient psychotherapy per beneficiary per financial year, Pre-authorisation and DSP Network.			
2.2.5 Treatment of chemical and substance abuse	Benefits shall be limited to the treatment of PMB conditions and subject to the following: - Pre-authorisation; - DSP Network; and - The length of stay shall be limited to 21 (twenty-one) days for in-hospital management per beneficiary per financial year.			
2.2.6 Consultations and procedures: Consultations, visits, operations, surgical procedures and anaesthetics for surgical procedures during hospitalisation.	Claims submitted by General Practitioners (GPs) and specialists for treatment during hospitalisation shall be paid at 100% of Scheme tariff/cost*.			
2.2.7 Organ transplants (in and/or out of hospital): Pre-authorisation must be obtained.	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules, and shall be paid at cost as per PMB regulations.			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.8 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.			
2.2.9 Blood transfusion	Blood, operators' fees, transport charges and apparatus payable at 100% of Scheme tariff/cost*.			
2.2.10 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% of Scheme tariff. - The treatment of certain PMB conditions, as per the standard of care in the State sector shall be paid at cost, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations.			
2.2.10.1 Dental and oral surgery (in and/or out of hospital):	Benefits shall be at 100% of Scheme tariff limited to R9 768 per family per financial year for the following procedures performed either in or out of hospital: - Surgical extractions of teeth / roots / impactions / failed implants;	Benefits shall be at 100% of Scheme tariff limited to R16 232 per family per financial year for the following procedures performed either in or out of hospital: - Surgical extractions of teeth / roots / impactions / failed implants;	Benefits shall be at 100% of Scheme tariff limited to R20 397 per family per financial year for the following procedures performed either in or out of hospital: - Surgical extractions of teeth / roots / impactions / failed implants;	Benefits shall be at 100% of Scheme tariff limited to R24 419 per family per financial year for the following procedures performed either in or out of hospital: - Surgical extractions of teeth / roots / impactions / failed implants; - Surgical drainage of dental abscess;

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Surgical drainage of dental abscess; - Alveolectomy / alveolotomy (preparatory surgery for dental prosthesis); - Root canal related surgery; - Dental implant related surgery; - Pre-prosthetic (preparatory to dental prosthetics) surgery; - Orthodontic related / orthognathic surgery.	- Surgical drainage of dental abscess; - Alveolectomy / alveolotomy (preparatory surgery for dental prosthesis); - Root canal related surgery; - Dental implant related surgery; - Pre-prosthetic (preparatory to dental prosthetics) surgery; - Orthodontic related / orthognathic surgery.	- Surgical drainage of dental abscess; - Alveolectomy / alveolotomy (preparatory surgery for dental prosthesis); - Root canal related surgery; - Dental implant related surgery; - Pre-prosthetic (preparatory to dental prosthetics) surgery; - Orthodontic related / orthognathic surgery.	- Alveolectomy / alveolotomy (preparatory surgery for dental prosthesis); - Root canal related surgery; - Dental implant related surgery; - Pre-prosthetic (preparatory to dental prosthetics) surgery; - Orthodontic related / orthognathic surgery.
2.2.10.2 Major maxillo-facial surgery, strictly related to certain conditions	Benefits shall be at 100% of Scheme tariff limited to R15 800 per family per financial year, strictly for the following conditions:	Benefits shall be at 100% of Scheme tariff strictly for the following conditions: - Severe trauma (soft tissue injuries, fractures of jaws and facial bones); - Cleft lip and palate; - Crouson’s disease; - Malunited craniomaxillary disjunction; - Post-traumatic defects (root residues in sinus, secondary oro-nasal fistula, faciostenosis);		

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- 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.	- Internal TM joint surgery (condylectomy, arthrocentesis, arthroplasty, total joint reconstruction); - Salivary gland surgery (removal of gland or salivary stone); - Life threatening sepsis (Ludwig's angina); and - Confirmed oral cancer.		

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.11 Prosthesis Benefits	Benefits shall subject to the following: - Pre-authorisation; - Preferred providers or DSPs; - The treatment of certain PMB conditions, as per the standard of care in the State sector shall be paid at cost, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations; and - Services for non-PMB conditions shall be based on Scheme tariff or contracted fee and shall be subject to exclusions for joint replacement surgery.			
2.2.11.1 Prosthesis – Internal Prosthesis surgically implanted during operations for the replacement of parts of the human body for functional medical reasons, including delivery systems and related items.	Benefits shall not be pro-rated and shall be paid at 100% of Scheme tariff/cost* limited to the overall limit of R109 167 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R71 390; - Pacemaker (single and dual chambers) limited to	Benefits shall not be pro-rated and shall be paid at 100% of Scheme tariff/cost* limited to the overall limit of R140 193 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R71 390; - Pacemaker (single and dual chambers) shall be	Benefits shall not be pro-rated and shall be paid at 100% of Scheme tariff/cost* limited to the overall limit of R140 912 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R75 783; - Pacemaker (single and dual chambers) shall be	Benefits shall not be pro-rated and shall be paid at 100% of Scheme tariff/cost* limited to the overall limit of R162 601 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R75 783; - Pacemaker (single and dual chambers) shall be limited

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	R67 943 and at DSP prices; - Endovascular and catheter-based procedures are subject to the Vascular prosthesis sub-limit and at DSP prices; - Spinal prosthesis including artificial disk (single level based) shall be limited to R39 788; - Drug-eluting stents are subject to the Vascular prosthesis sub-limit and at DSP prices; - Mesh shall be limited to R14 939; - Gynaecological/Urological prosthesis shall be limited to R10 773;	limited to R75 770 and at DSP prices; Endovascular and catheter base procedures are subject to the Vascular prosthesis sub-limit and at DSP prices; - Spinal prosthesis including artificial disk (single level based) shall be limited to R70 284; - Drug-eluting stents shall be limited to R22 983 and at DSP prices; - Mesh shall be limited to R22 983; - Gynaecological/Urological prosthesis shall be limited to R17 164; - Lens implant shall be limited to R14 738 a lens per eye;	limited to R75 770 and at DSP prices; - Endovascular and catheter base procedures are subject to the Vascular prosthesis sub-limit and at DSP prices; - Spinal prosthesis including artificial disk (single level based) shall be limited to R70 418; - Drug-eluting stents shall be limited to R22 983 and at DSP prices; - Mesh shall be limited to R22 983; - Gynaecological/Urological prosthesis shall be limited to R17 237; - Lens implant shall be limited to R14 738 a lens per eye;	to R75 770 and at DSP prices; - Endovascular and catheter base procedures are subject to the Vascular prosthesis sub-limit and at DSP prices; - Spinal prosthesis including artificial disk (single level based) shall be limited to R81 308; - Drug-eluting stents shall be limited to R27 077 and at DSP prices; - Mesh shall be limited to R23 845; - Gynaecological/Urological prosthesis shall be limited to R19 679; - Lens implant shall be limited to R21 790 a lens per eye;

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Lens implant shall be limited to R8 188 a lens per eye; - Functional prosthesis – items used to replace or augment an impaired bodily function - shall be limited to R37 342.	- Hip prosthesis and other major joints shall be limited to R63 129; - Knee prosthesis shall be limited to R73 257; - Other minor joints shall be limited to R27 219; and - Functional prosthesis – items used to replace or augment an impaired bodily function - shall be limited to R39 539.	- Hip prosthesis and other major joints shall be limited to R63 201; - Knee prosthesis shall be limited to R73 615; - Other Minor joints shall be limited to R27 219; and - Functional prosthesis – items used to replace or augment an impaired bodily function - shall be limited to R39 539.	- Hip prosthesis and other major joints shall be limited to R72 755; - Knee prosthesis shall be limited to R84 245; - Other Minor joints shall be limited to R27 077; and - Functional prosthesis – items used to replace or augment an impaired bodily function - shall be limited to R43 932.
2.2.11.2 Prosthesis – External: Prosthesis used after operations for the replacement of parts of the human body for functional medical reasons, including delivery systems and related items. A list of prostheses covered by the Scheme can be requested from the Scheme.	Benefits shall be at 100% of Scheme tariff limited to R27 723 per family per financial year: - 2 (two) quotations may be required; - Preferred providers or DSPs; and - Artificial limbs are limited to 1 (one) limb every 60	Benefits shall be at 100% of Scheme tariff limited to R33 037 per family per financial year: - 2 (two) quotations may be required; - Preferred providers or DSPs; and - Artificial limbs are limited to 1 (one) limb every 60	Benefits shall be at 100% of Scheme tariff limited to R33 182 per family per financial year: - 2 (two) quotations may be required; - Preferred providers or DSPs; and - Artificial limbs are limited to 1 (one) limb every 60	Benefits shall be at 100% of Scheme tariff limited to R37 491 per family per financial year: - 2 (two) quotations may be required; - Preferred providers or DSPs; and - Artificial limbs are limited to 1 (one) limb every 60 (sixty)

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

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Hip prosthesis and other major joints shall be limited to R40 506; - Knee prosthesis shall be limited to R53 866; and - Other minor joints shall be limited to R16 735.			
2.2.12 Medically necessary breast reduction surgery Including fees for the surgeon and anaesthetist	No benefit			Benefits shall be at 100% of Scheme tariff limited to R58 046 per family per financial year, subject to Pre-authorisation and protocols.
2.2.13 Orthopaedic and medical appliances during hospitalisation: Appliances directly related to the hospital admission and/or procedure.	Benefits shall be at 100% of Scheme tariff/cost* limited to R15 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.			
2.2.14 Pathology during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*.			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.15 Basic radiology during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*.			
2.2.16 Specialised diagnostic imaging (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. Pre-authorisation must be obtained for all specialised diagnostic imaging benefits.	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: - 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.	Benefits shall be at 100% of Scheme tariff/cost* limited to a combined in and out of hospital benefit of R42 000 per family per financial year, subject to the following: - A co-payment of R1 500 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.		Benefits shall be at 100% of Scheme tariff/cost* limited to a combined in and out of hospital benefit of R45 000 per family per financial year, subject to the following: - A co-payment of R1 500 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.
2.2.17 Oncology benefits (in or out of hospital)	Oncology Programme. Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.18 Breast surgery for cancer	Treatment of the unaffected (non-cancerous) breast shall be limited to PMB provisions and is subject to Pre-authorisation and funding guidelines.			
2.2.19 Peritoneal dialysis and haemodialysis (in or out of hospital)	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.			
2.2.20 HIV/AIDS benefits (in or out of hospital)	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.			
2.2.21 Confinements	Benefits shall be at 100% of Scheme tariff/cost*, even if the baby dies before registration, for the following: - Medical practitioners; - Nursing home and hospital fees in accordance with the provisions of the "Hospitalisation" benefit; - Midwife assisted births in an Active Hospital Birth Unit or home confinement by a midwife. Transport fees, hospital facility fees, renting of a birth pool, medical disposables or medication, antenatal consultations, doulas and breastfeeding support shall be excluded from benefits if these are not PMB level of care; and - Midwife assisted births at a private midwife birth house. Transport fees, renting of a birth pool, antenatal consultations, doulas and breastfeeding supports shall be excluded from benefits if these are not PMB level of care.			
2.2.22 Refractive surgery and other procedures done to improve or stabilise vision, except for cataracts	Benefits shall be at 100% of Scheme tariff limited to R10 859 per eye, subject to Pre-authorisation and protocols.	Benefits shall be at 100% of Scheme tariff limited to R11 347 per eye, subject to Pre-authorisation and protocols.	Benefits shall be at 100% of Scheme tariff limited to R12 210 per eye, subject to Pre-authorisation and protocols.	

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.23 Supplementary services during hospitalisation	Benefits shall be at 100% of Scheme tariff/cost*, provided that the services are related to the hospital admission of the patient and are in line with the Scheme funding guidelines and protocols, for supplementary services which include services rendered by physiotherapists, masseurs, chiropractors, osteopaths, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech therapists, biokinetics, stoma therapist and social workers.			
2.2.24 Alternatives to hospitalisation (i.e. procedures done in the doctor's rooms)	Benefits shall be at 100% of Scheme tariff subject to: - Pre-authorisation; - Step-down facilities approved by the Scheme; and - Services must be rendered by registered private nurses and hospices.			
2.2.25 Advance illness benefit	Benefits shall be at 100% of Scheme tariff/cost* limited to R87 068 per beneficiary per financial year, subject to Pre-authorisation and treatment plan.	Benefits shall be at 100% of Scheme tariff/cost* limited to R139 308 per beneficiary per financial year, subject to Pre-authorisation and treatment plan.		
2.2.26 Ambulance and emergency evacuation services	Benefits shall be subject to: - Provision of benefits by Netcare 911, as the Scheme's capitated preferred provider for ambulance services. - Benefits shall only be payable if the evacuation service was involuntarily requested and delivered by a service provider other than the preferred provider: Provided that services in respect of PMB conditions shall be payable at cost, without deductibles or the use of co-payments, subject to the provisions of Rule 15.10 of the main rules read in conjunction with Annexure D.1 of these Rules, as shall be evaluated by the Scheme.			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.2.27 International emergency medical cover	In addition to the provisions for foreign claims referred to in Rule 16.12 of the registered Bestmed Rules, the Member and his Dependant(s) qualify for additional benefits which shall be at 100% contracted tariff subject to the following: - Provision of benefits by Europ Assistance SA, as the Scheme's capitated preferred provider for international travel insurance. - Cover for leisure and business travel for emergency medical and related expenses: ▪ Leisure travel is limited to 90 (ninety) days and R1 million cover for travelling to the United States of America (USA) for a family i.e. Member and Dependant(s). All other countries are covered up to 90 (ninety) days for R5 million for a family i.e. Member and Dependant(s). ▪ Business travel is limited to 60 (sixty) days and R1 million cover for travelling to the USA for a family i.e. Member and Dependant(s). All other countries are covered up to 60 (sixty) days for R5 million for a family i.e. Member and Dependant(s). - A Member must give at least 48 (forty-eight) hours in advance when he and/or his Dependant(s) are 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.			
2.2.28 Day procedures at a day hospital facility	Day procedures at a day hospital or day clinic facility shall be funded at 100% of Scheme tariff/cost*, subject to: - Pre-authorisation; - Protocols and funding guidelines; and - DSPs and preferred providers			

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	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.			

2.3. MEDICINE BENEFITS

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

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

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
- Approved PMB, CDL and non-CDL chronic medicine costs shall be paid from the non-CDL limit first. Thereafter, only approved PMB and CDL chronic medicine costs shall be paid by the Scheme. Approved treatment for organ transplant, chronic renal failure, multiple sclerosis and haemophilia will be paid directly from Scheme risk and not non-CDL limit. - Approved PMB biological and non-PMB biological medicine costs shall be paid from the applicable biological medicine limit first. Thereafter, only approved PMB biological medicine costs shall be paid by the Scheme.				
2.3.1 Chronic medicine not listed on the chronic disease list ("non-CDL medicine")	Medicine on the formulary shall be covered at 90% of Scheme tariff with a 10% co-payment and non-formulary medicine shall be covered at 75% of Scheme tariff with a 25% co-payment. Payment shall be at Scheme tariff limited to M = R8 044 and M1+ = R16 087 for the following 7 (seven) non-CDL conditions: - Acne - Allergic rhinitis	Medicine on the formulary shall be covered at 90% of Scheme tariff with a 10% co-payment and non-formulary medicine shall be covered at 80% of Scheme tariff with a 20% co-payment. Payment shall be at Scheme tariff limited to M = R10 983 and M1+ = R21 966 for the following 20 (twenty) non-CDL conditions: - Acne - Allergic rhinitis	Medicine on the formulary shall be covered at 90% of Scheme tariff with a 10% co-payment and non-formulary medicine shall be covered at 85% of Scheme tariff with a 15% co-payment. Payment shall be at Scheme tariff limited to M = R16 878 and M1+ = R33 757 for the following 20 (twenty) non-CDL conditions: - Acne - Allergic rhinitis	Medicine on the formulary shall be covered at 100% of Scheme tariff and non-formulary medicine shall be covered at 90% of Scheme tariff with a 10% co-payment. Payment shall be at Scheme tariff limited to M = R24 058 and M1+ = R48 335 for the following 29 (twenty-nine) non-CDL conditions: - Acne - Allergic rhinitis - Ankylosing Spondylitis

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Eczema - Gout Prophylaxis** - Major Depression** shall be covered as a life-sustaining condition once the non-CDL benefit limit has been depleted - Migraine prophylaxis Subject to: - Prior application and approval by the Scheme and benefits shall be from the date on which the application was	- Ankylosing Spondylitis - Alzheimer's disease - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Autism - Collagen diseases - Dermatomyositis - Eczema - Gastro Oesophageal Reflux Disease (GORD)** - Gout Prophylaxis** - Major Depression** shall be covered as a life-sustaining condition once the non-CDL benefit limit has been depleted - Migraine prophylaxis	- Ankylosing Spondylitis - Alzheimer's disease - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Autism - Collagen diseases - Dermatomyositis - Eczema - Gastro Oesophageal Reflux Disease (GORD)** - Gout Prophylaxis** - Major Depression** shall be covered as a life-sustaining condition once the non-CDL benefit limit has been depleted - Migraine prophylaxis	- Alzheimer's disease - Attention Deficit Disorder (ADD)/Attention Deficit Hyperactive Disorder (ADHD) - Autism - Blepharospasm - Collagen diseases - Dermatomyositis - Dystonia** - for ongoing or long-term chronic use - Eczema - Gastro Oesophageal Reflux Disease (GORD)** - Gout Prophylaxis** - Hypopituitarism - Major Depression** shall be covered as a life-sustaining condition once the non-CDL benefit limit has been depleted - Migraine prophylaxis

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

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
				by the Scheme or its proxy.
2.3.2 Medicine for PMB conditions including the conditions listed on the chronic disease list (CDL)	Medicine on the formulary shall be covered at 100% Scheme tariff/cost* with no co-payment and voluntary use of non-formulary medicine shall be covered at 75% of Scheme tariff with a 25% co-payment. Subject to: Prior application and approval by the Scheme.	Medicine on the formulary shall be covered at 100% Scheme tariff/cost* with no co-payment and voluntary use of non-formulary medicine shall be covered at 80% of Scheme tariff with a 20% co-payment. Subject to: Prior application and approval by the Scheme.	Medicine on the formulary shall be covered at 100% Scheme tariff/cost* with no co-payment and voluntary use of non-formulary medicine shall be covered at 85% of Scheme tariff with a 15% co-payment. Subject to: Prior application and approval by the Scheme.	Medicine on the formulary shall be covered at 100% Scheme tariff/cost* with no co-payment and voluntary use of non-formulary medicine shall be covered at 90% of Scheme tariff with a 10% co-payment. Subject to: Prior application and approval by the Scheme.
2.3.3 Biological medicine: Biological medicine is a substance that is made from a living organism or its products and is used in the 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	Subject to pre-approval, the benefits shall be paid at 100% of Scheme tariff/cost* with a maximum of R200 964 per beneficiary per financial year.	Subject to pre-approval, the benefits shall be paid at 100% of Scheme tariff/cost* with a maximum of R402 194 per beneficiary per financial year.	Subject to pre-approval, the benefits shall be paid at 100% of Scheme tariff/cost* with a maximum of R595 247 per beneficiary per financial year.

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	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.			
2.3.4 Other high-cost medicine	Benefits shall be at 100% of Scheme tariff/cost* and subject to pre-approval.			
2.3.5 Acute medicine	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be subject to the overall day-to-day limit and the following maxima per financial year: M = R2 846 and M1+ = R5 890 Benefits shall be for:	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be subject to the overall day-to-day limit and the following maxima per financial year: M = R3 295 and M1+ = R6 590 Benefits shall be for:	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be subject to the overall day-to-day limit and the following maxima per financial year: M = R2 197 and M1+ = R4 942 Benefits shall be for:	Benefits shall be subject to the overall day-to-day limit and the following maxima per financial year: M = R10 260 and M1+ = R15 938 Benefits shall be for: - Medicine prescribed out of a hospital by a medical practitioner, a contracted Pharmacist Primary Care Drug Therapy (PCDT)

* As per the provisions of Rule 2.1.8.

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

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
2.3.6 Over-the-counter (OTC) medicine The member may choose how to access OTC medicine benefits: 1. The OTC medicine benefit with a set limit on the PMSA. OR 2. The OTC medicine benefit without a set limit on the PMSA to accumulate a self-payment gap.	1. The OTC medicine benefit up to the limit of R1 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 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 beginning of the year, or pro-rated if the Member joins after January, from which OTC medicine purchases, in excess of the aforementioned set limit, will accumulate to a self-payment gap. 2.2 Once a self-payment gap has accumulated, the day-to-day health care services, as indicated in Rule 2.7 of this Annexure, will contribute towards the payment of the self-payment gap, thus reducing and ultimately closing the self-payment gap. The Member			100% of the Scheme tariff, subject only to funds being available in the PMSA. Benefit includes, but not limited to, purchases of sunscreen, vitamins and minerals with nappi codes on the Scheme's formulary.

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

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	Adult group: - Twice in a lifetime, with a booster if beneficiary is above 65 (sixty-five) years of age. - The Scheme in accordance with its protocol, will identify certain high-risk individuals who will be advised to be immunised.			
2.4.3 Travel vaccinations	Bestmed provides cover for certain mandatory travel vaccines for typhoid, yellow fever, tetanus, meningitis, hepatitis and cholera from Scheme risk benefits.			
2.4.4 Baby growth and development assessments	Children from 0 (zero) up to 2 (two) years of age: - 3 (three) assessments per year. - Assessments must be conducted at a pharmacy clinic or by a registered nurse.			
2.4.5 Paediatric immunisations	Paediatric vaccines according to the State recommended programme for babies and children.			
2.4.6 Female contraceptives	Applicable to all females of childbearing age: - Quantity and frequency depending on product up to the maximum of R2 678 per beneficiary per financial year, which includes all items classified in 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.			
2.4.7 Preventative dentistry	Benefits are applicable per beneficiary: **1. General full mouth examination by a general dentist (incl. gloves and use of sterile equipment for this visit):** - For beneficiaries under 12 (twelve) years - twice per financial year. - For beneficiaries 12 (twelve) years and older - once per financial year. **2. Full mouth intra-oral radiographs:** All ages, once every 36 (thirty-six) months. **3. Intra-oral radiograph:** All ages, 2 (two) x photos per financial year.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	4. Scaling and/or polishing: All ages, every 6 (six) months from the date of service. **5. Fluoride treatment:** All ages, every 6 (six) months from the date of service. **6. Fissure sealing:** Beneficiaries up to and including 21 (twenty-one) years, the frequency will be in accordance with accepted protocol. **7. Space maintainers:** During primary and mixed denture stage, once per space.			
2.4.8 Mammogram	Females 40 (forty) years and older - once every 24 (twenty-four) months.			
2.4.9 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).			
2.4.10 Bone densitometry	No benefit	Once every 24 (twenty-four) months for all beneficiaries 45 (forty-five) years and older.		
2.4.11 Prostate Specific Antigen (PSA) test: Tariff codes claimed by pathologists or nappi codes claimed by pharmacies in respect of this benefit are included.	Males 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.			
2.4.12 PAP smear: Tariff codes claimed by pathologists or nappi codes	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	PACE1	PACE2	PACE3	PACE4
claimed by pharmacies in respect of this benefit are included.	- To be done at a gynaecologist or GP. - Consultation fee paid from the Preventative Care benefit.			
2.4.13 Glaucoma screening	No benefit	Preventative benefit is subject to: - Beneficiaries 50 (fifty) years and older. - Once every 12 (twelve) months per beneficiary. - To be performed by preferred optical network optometrists.		
2.4.14 Tempo programme: Benefits on the Tempo programme can only be accessed when a beneficiary undergoes a lifestyle screening.	**1. Tempo Lifestyle Screening** Beneficiaries 16 (sixteen) years and older - 1 (one) per beneficiary per financial year. - This includes a biometric screening and lifestyle questionnaire that must be completed at Network pharmacy clinics, or onsite at selected Employer groups, or at an accredited Tempo biokineticist, or a Tempo GP. Only participating Employer groups which allow onsite screening and nurses onsite, or allow the Scheme to conduct the lifestyle screening at the workplace. Alternatively, Members can obtain the services from their pharmacy clinics or accredited Tempo biokineticists or nurses. - Beneficiaries must complete a lifestyle screening in order to unlock the biokineticist and dietician consultations that form 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	PACE1	PACE2	PACE3	PACE4
	Nutrition - 1 (one) nutritional assessment at a Tempo dietician; and - 1 (one) follow-up in person or virtual consultation at a Tempo dietician to obtain a personalised diet plan.			
2.5 MATERNITY BENEFITS	Benefits shall be at 100% of Scheme tariff per beneficiary per 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.			
2.6 OPTOMETRY BENEFITS	Optometry benefits are available per beneficiary every 24 (twenty-four) months from the date of service. Services rendered by the designated optical network, Preferred Provider Negotiators (PPN), optometrists shall be payable at 100% of contracted fee. Services rendered by a non-network provider shall be paid at 100% Scheme tariff subject to the maxima indicated.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	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 - 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:	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 260 AND - Lenses: standard lenses (i.e. single vision or bifocal or multifocal lenses) at 100% of cost as well as lens enhancements limited to R750 OR - Contact lenses limited to R2 215 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 R945 AND - Lenses additional lens enhancements of R563: Single-vision lenses at R215 OR Bifocal lenses at R460 OR Multifocal lenses at R1 040 (consisting of R810 per base lens plus R230 per branded lens add-on)		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 260 AND - Lenses: standard lenses (i.e. single vision or bifocal or multifocal lenses) at 100% of cost as well as lens enhancements limited to R750 OR - Contact lenses limited to R2 620 Benefits from a non-network provider shall be as follows: - Consultations: 1 (one) per beneficiary limited to R400

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Consultations: 1 (one) per beneficiary limited to R400 - Spectacle frames or lens enhancements limited to R908 AND - Lenses: Single-vision lenses at R215 OR Bifocal lenses at R460 OR Multifocal lenses at 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 at R2 025	- In lieu of glasses Members can opt for contact lenses at R2 215		- Spectacle frames or lens enhancements limited to R945 AND - Lenses additional lens enhancements of R563: Single-vision lenses at R215 OR Bifocal lenses at R460 OR Multifocal lenses at 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 at R2 620
2.7 OUT-OF-HOSPITAL BENEFITS	- Refer to Annexure B.4 for the conditions of payment from the Personal Medical Savings Account (PMSA) and the Vested Medical Savings Account.			

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	- Full cross subsidisation between Members shall apply without an annual limit, except in relation to the PMSA. - Day-to-day benefits may be subject to payment from the PMSA first and shall be indicated as such. - Benefits may be subject to the annual maxima for the Member with his Dependant(s) and/or as provided for on the benefit. - Benefits shall be paid at 100% of Scheme tariff/cost*as per the standard of care in the State sector.			
	The following combined overall limit for day-to-day benefits shall apply per financial year: M = R13 187 and M1+= R26 373	The following combined overall limit for day-to-day benefits shall apply per financial year: M = R16 475 and M1+= R32 949	The following combined overall limit for day-to-day benefits shall apply per financial year: M = R22 015 and M1+= R45 497	The following combined overall limit for day-to-day benefits shall apply per financial year: M = R43 380 and M1+= R69 954
2.7.1 GP, nurse and specialist consultations Consultations, visits, diagnostic examinations, injections and emergency unit visits (where a procedure room was used) with General Practitioners, contracted Nursing Clinical Services, contracted Pharmacist Primary Care Drug Therapy (PCDT)	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:	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:	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:	Benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R6 823 and M1+ = R11 061

* As per the provisions of Rule 2.1.8.

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
pharmacists, Specialists, Homeopaths and Herbalists.	M = R2 715 and M1+ = R5 459	M = R5 029 and M1+ = R10 192	M = R5 316 and M1+ = R10 773	
2.7.2 Continuous/Flash Glucose Monitoring (CGM/FGM) benefit for Diabetics	Subject to the Medical Aids, apparatus and appliance benefit		Continuous/Flash Glucose Monitoring (CGM/FGM) at 100% of Scheme tariff limited to R23 218 per family per financial year, subject to Pre-authorisation.	Continuous/Flash Glucose Monitoring (CGM/FGM) at 100% of Scheme tariff limited to R29 022 per family per financial year, subject to Pre-authorisation.
2.7.3 Basic and specialised dentistry Includes basic and specialised dentistry not defined under Preventative dentistry benefits or Dental / Oral / Jaw surgical benefits.	Basic and specialised dentistry benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R4 998 and M1+ = R10 142	Basic and specialised dentistry benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R8 377 and M1+ = R16 756	Basic and specialised dentistry benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R9 027 and M1+ = R16 829	Basic and specialised dentistry benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R15 066 and M1+ = R25 428 Specialised dentistry benefits include:

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	Specialised dentistry benefits include: - Prosthodontics services (crowns, bridges, inlays, veneers and dentures); - Periodontics services (gum diseases); - Orthodontic services (correction of irregular teeth by means of braces, retainers or similar treatment) are subject to Pre-authorisation; and - Dental implants, implant costs and all laboratory costs related to the aforementioned services.	Specialised dentistry benefits include: - Prosthodontics services (crowns, bridges, inlays, veneers and dentures); - Periodontics services (gum diseases); - Orthodontic services (correction of irregular teeth by means of braces, retainers or similar) for beneficiaries over the age of 18 (eighteen) years are subject to Pre-authorisation; and - Dental implants, implant costs and all laboratory costs related to the aforementioned services.	Specialised dentistry benefits include: - Prosthodontics services (crowns, bridges, inlays, veneers and dentures); - Periodontics services (gum diseases); - Orthodontic services (correction of irregular teeth by means of braces, retainers or similar) for beneficiaries over the age of 18 (eighteen) years are subject to Pre-authorisation; and - Dental implants, implant costs and all laboratory costs related to the aforementioned services.	- Prosthodontics services (crowns, bridges, inlays, veneers and dentures); - Periodontics services (gum diseases); - Orthodontic services (correction of irregular teeth by means of braces, retainers or similar) for beneficiaries over the age of 18 (eighteen) years are subject to Pre-authorisation; and - Dental implants, implant costs and all laboratory costs related to the aforementioned services.
		Orthodontic services (correction of irregular teeth by means of braces,	Orthodontic services (correction of irregular teeth by means of braces,	Orthodontic services (correction of irregular teeth by means of braces, retainers, or

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
		retainers, or similar treatment) for beneficiaries up to 18 (eighteen) years of age. Pre-authorisation is required and benefits shall be at 100% of Scheme tariff. Claims shall be paid from the PMSA first. Once the funds in the PMSA have been depleted, benefits shall be limited to R8 126 per event per financial year, subject to the overall day-to-day limit.	retainers, or similar treatment) for beneficiaries up to 18 (eighteen) years of age. Pre-authorisation is required and benefits shall be at 100% of Scheme tariff. Claims shall be paid from the PMSA first. Once the funds in the PMSA have been depleted, benefits shall be limited to R10 448 per event per financial year, subject to the overall day-to-day limit.	similar treatment) for beneficiaries up to 18 (eighteen) years of age. Pre-authorisation is required and benefits shall be at 100% of Scheme tariff limited to R12 770 per event per financial year, subject to the overall day-to-day limit.
2.7.4 Medical aids, apparatus and appliances, including wheelchairs and hearing aids Pre-authorisation must be obtained for all hearing aid devices fitted	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	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R12 640 per family per financial year for appliances that shall include any of the items listed below: - Back, leg, arm and neck support;		Benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R12 640 per family per financial year for appliances that shall include any of the items listed below:

<table>
<tr><th>HEALTHCARE SERVICES</th><th>PACE1</th><th>PACE2</th><th>PACE3</th><th>PACE4</th></tr>
<tr><td rowspan="3">and the following documentation is required:

- A fully detailed audiogram;
- A comprehensive quotation, which includes, inter alia, the product name, clinical details (i.e. behind the ear, in the ear, custom) and the number of devices to be fitted;
- NAPPI code(s);
- Motivation for obtaining a hearing aid device; and
- In the case of providers who are not contracted with the Scheme, the product serial number(s) of the hearing aid device(s).</td><td>R13 934 per family per financial year for appliances that shall include any of the items listed below:

- Back, leg, arm and neck support;
- Wheelchairs;
- Surgical footwear;
- Crutches;
- Elastic stockings;
- Repair work on artificial limbs, wheelchairs, etc.; and
- Stoma products, Oxygen and Diabetic supplies for non-PMB conditions.</td><td colspan="2">- Surgical footwear;
- Crutches;
- Elastic stockings;
- Repair work on artificial limbs, wheelchairs, etc.;
- Stoma products, and
- Oxygen and Diabetic supplies for non-PMB conditions.</td><td>- Back, leg, arm and neck support;
- Surgical footwear;
- Crutches;
- Elastic stockings;
- Repair work on artificial limbs, wheelchairs, etc.;
- Stoma products,
- Oxygen supplies and Diabetic supplies for non-PMB conditions; and
- Insulin pump consumables.</td></tr>
<tr><td colspan="3">Wheelchairs at 100% of Scheme tariff limited to R17 094 per family every 48 (forty-eight) months.</td></tr>
<tr><td>Hearing aids and/or repair at 100% of Scheme tariff limited to R9 678 per family once every 24 (twenty-four) months.</td><td>Hearing aids and/or repair at 100% of Scheme tariff limited to R32 000 per beneficiary every 24 (twenty-four) months.</td><td>Hearing aids and/or repair at 100% of Scheme tariff limited to R32 000 per beneficiary every 24 (twenty-four) months.</td><td>Hearing aids and/or repair at 100% of Scheme tariff limited to R35 000 per beneficiary every 24 (twenty-four) months.</td></tr>
</table>

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
	Pre-authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 2.7.4.	Pre-authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 2.7.4.	Pre-authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 2.7.4.	Pre-authorisation is required together with the documentation indicated on the Healthcare Services on this Rule 2.7.4. Insulin pump, excluding consumables, at 100% of Scheme tariff limited to R50 806 per beneficiary every 24 (twenty-four) months. Pre-authorisation is required.
2.7.5 Supplementary services Benefits includes services rendered by physiotherapists, masseurs, chiropractors, osteopaths, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech therapists, biokinetics, private nursing (stoma therapy nursing, obtaining of	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:	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:	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:	Benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R6 823 and M1+ = R13 430

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
specimen, observations and administration of medication, immunisations and IV's), psychiatric treatment, psychologists and social workers.	M = R5 329 and M1+ = R11 061	M = R3 844 and M1+ = R7 688	M = R3 247 and M1+ = R6 823	
2.7.6 Wound care benefit Includes dressings and negative pressure wound therapy (NPWT) treatment and nursing services out of hospital.	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R4 381 per family per financial year.	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R7 882 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 R10 983 per family per financial year.	Benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and R16 663 per family per financial year.
2.7.7 Basic radiology and pathology	Benefits shall be at 100% of Scheme tariff from the PMSA. Once the funds in the PMSA have been depleted, benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R3 950 and M1+ = R7 901		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	Benefits shall be at 100% of Scheme tariff subject to the overall day-to-day limit and the following maxima per financial year: M = R6 823 and M1+ = R13 430

HEALTHCARE SERVICES	PACE1	PACE2	PACE3	PACE4
			the following maxima per financial year: M = R4 310 and M1+ = R8 546	
2.7.8 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. Based on the first assessment, a rehabilitation treatment plan is drawn up and initiated over an uninterrupted period that will be specified by the provider.			
2.7.9 Rehabilitation after trauma Benefits for rehabilitation shall be aimed at the recovery of impeded vital functions immediately after trauma such as a stroke or heart attack.	Benefits shall be payable at 100% of Scheme tariff/cost*.			

* As per the provisions of Rule 2.1.8.