ANNEXURE B.3 – BENEFIT OPTIONS
2025 RHYTHM RANGE

3.1 GENERAL CONDITIONS OF THE BENEFIT OPTIONS

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

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

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

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

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

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

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

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

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

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

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

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2

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

- All hospital and hospital-related benefits shall be subject to Pre-authorisation, major medical expenses which require Pre-authorisation shall be indicated.
- Comprehensive benefits are offered for all pre-authorised services and authorised emergency services rendered during hospitalisation, i.e. from the day of admission up to and including the day of discharge.
- No benefits in a private hospital or day clinic shall be granted by the Scheme or its proxy if Pre-authorisation and an authorisation number have not been obtained:
  - In the event of planned major operations and dental procedures, Members are advised to obtain Pre-authorisation at least 2 (two) weeks in advance to ensure that the Member is aware of applicable benefits, limits, network restrictions, etc., before the event.
  - In an emergency, on the 1st (first) working day after admission to a hospital, or at the first reasonable opportunity as may be determined by the Scheme.
- Late authorisations will be subject to, but not limited to, clinical review, application of rules, benefits, protocols, funding guidelines, as well as the PMB status of the services rendered.
- If Pre-authorisation and an authorisation number have been obtained for treatment in a private hospital or day clinic but the treatment cost exceeds the authorised benefits, only the benefits of the authorised treatment cost shall be granted and the Member shall be liable for payment of the excess to the service provider, unless if the excess costs were as a direct result of treatment received and necessary for the beneficiary and authorisation could not be obtained in time.
- No benefits in respect of MRI scans and computer tomographic studies shall be granted if an authorisation number has not been obtained in advance or, in an emergency, on the 1st (first) working day after admission to a hospital, by the Scheme or its proxy.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2

- Full cross subsidisation between Members shall apply without an annual limit.
- The Scheme's list of Hospital Network DSP (contracted private hospitals) 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 3.2.28 per hospital admission shall apply on the following:
    - Arthroscopic procedures
    - Back and neck surgery
    - Laparoscopic procedures
    - Colonoscopies
    - Cystoscopies
    - Gastroscopies
    - Hysteroscopies
    - Sigmoidoscopies
    - Extraction of wisdom teeth
  - A co-payment of a specified amount indicated in Rule 3.2.16 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 3.2.27 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 3.2.28 shall apply on the Rhythm1 and Rhythm2 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	RHYTHM1	RHYTHM2
3.2.1 Hospitalisation: Pre-authorisation required for accommodation (hospital stay) in a general ward, intensive-care and high-care unit, theatre and material.	Benefits shall be limited to the treatment of PMB conditions and to DSP Network.	Benefits shall be at 100% of Scheme tariff/cost*. DSP Network applies.
3.2.2 Take-home medicine: Medicine supplied by the hospital when a patient is discharged.	Medicine prescribed by the treating provider for a patient discharged from hospital, relating to the admission, to take home will be paid at 100% of Scheme tariff/cost* for a maximum supply of 7 (seven) days provided that: - the medicine is claimed as part of the hospital account; or - the medicine 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.	
3.2.3 Biological medicine during hospitalisation Biological medicine is a substance that is made from a living organism or its products and is used in the prevention, diagnosis, or treatment of acute and chronic diseases.	Benefits shall be limited to the treatment of PMB conditions and to DSP Network.	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and limited to R17 414 per family per financial year.
3.2.4 Treatment in mental health clinics	Benefits shall be limited to the treatment of PMB conditions at DSPs and subject to the length of stay limited to 21 (twenty-one) days	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

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	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 and Pre-authorisation.	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.
3.2.5 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.	
3.2.6 Consultations and procedures: Consultations, visits, operations, surgical procedures and anaesthetics for surgical procedures during hospitalisation. Pre-authorisation must be obtained.	Benefits shall be limited to the treatment of PMB conditions and to DSP Network.	Claims submitted by General Practitioners (GPs) and specialists for treatment during hospitalisation shall be paid at 100% of Scheme tariff/cost*. DSP Network applies.
3.2.7 Organ transplants (in and/or out of hospital): Pre-authorisation must be obtained.	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules underlined by PMB regulations, and shall be paid at cost.	

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
3.2.8 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.	
3.2.9 Blood transfusion	Blood, operators' fees, transport charges and apparatus payable at 100% of Scheme tariff/cost*.	
3.2.10 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.	
3.2.10.1 Dental and oral surgery (in and/or out of hospital)	No benefit, except in respect of PMB conditions.	
3.2.10.2 Major maxillo-facial surgery, strictly related to certain conditions	No benefit, except in respect of PMB conditions.	
3.2.11 Prosthesis Benefits	Benefits are subject to the following: - Pre-authorisation; - Limited to DSPs only; - Services for non-PMB conditions shall be based on Scheme tariff or contracted fee	Benefits are subject to the following: - Pre-authorisation; - Preferred providers or DSPs; - Services for non-PMB conditions shall be based on Scheme tariff or contracted fee and may be subject to exclusions for joint replacement surgery; and

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	and may be subject to exclusions for joint replacement surgery; and - The treatment of certain PMB conditions, as per the standard of care in the State sector shall be paid at cost, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations.	- The treatment of certain PMB conditions, as per the standard of care in the State sector shall be paid at cost, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations.
3.2.11.1 Prosthesis – Internal Prosthesis surgically implanted during operations for the replacement of parts of the human body for functional medical reasons, including delivery systems and related items.	Benefits shall be limited to the treatment of PMB conditions and DSPs. Benefits shall not be pro-rated and shall be paid at 100% of Scheme tariff/cost* limited to the overall limit of R64 208 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R54 915; - Pacemaker (single and dual chambers) limited to R51 998 and DSP prices;	Benefits shall not be pro-rated and shall be paid at 100% of Scheme tariff/cost* limited to the overall limit of R64 208 per family per financial year. Sub-limits per beneficiary per financial year: - Vascular prosthesis shall be limited to R54 915; - Pacemaker (single and dual chambers) limited to R51 998 and DSP prices; - Endovascular and catheter-based procedures are subject to the Vascular prosthesis sub-limit and DSP prices;

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	- Endovascular and catheter-based procedures are subject to the Vascular prosthesis sub-limit and DSP prices ; - Spinal prosthesis including artificial disk (single level based) shall be limited to R31 815; - Drug-eluting stents are subject to the Vascular prosthesis sub-limit and DSP prices; - Mesh shall be limited to R11 636; - Gynaecological/Urological prosthesis shall be limited to R9 611; - Lens implant shall be limited to R6 681 a lens per eye; - Functional prosthesis – items utilised towards treating or supporting a bodily function - shall be limited to R34 047.	- Spinal prosthesis including artificial disk (single level based) shall be limited to R31 815; - Drug-eluting stents are subject to the Vascular prosthesis sub-limit and DSP prices; - Mesh shall be limited to R11 636; - Gynaecological/Urological prosthesis shall be limited to R9 611; - Lens implant shall be limited to R6 681 a lens per eye; - Functional prosthesis – items utilised towards treating or supporting a bodily function - shall be limited to R34 047.
3.2.11.2 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	No benefit, except in respect of PMB conditions.	

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
covered by the Scheme can be requested from the Scheme.		
3.2.11.3 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 prosthesis and other major joints shall be limited to R32 607; - Knee prosthesis shall be limited to R41 226; and - Other minor joints shall be limited to R15 441. Functional nasal surgery and surgery procedures where CNS stimulators are used for example epilepsy, Parkinsonism, etc. will be excluded from benefits except for PMB conditions.	
3.2.12 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.	
3.2.13 Orthopaedic and medical appliances during hospitalisation Pre-authorisation must be obtained. Appliances directly related to the hospital admission and/or procedure.	Benefits shall be limited to the treatment of PMB conditions and DSPs for back, leg, arm and neck support, crutches, surgical footwear (excluding health footwear) and elastic stockings provided directly related to the admission and provided before discharge from hospital.	Benefits shall be at 100% of Scheme tariff/cost* limited to R7 901 per family per financial year for medically necessary appliances subject to PMB level of care for the items listed below, if prescribed by a medical practitioner and where such a prescription directly relates to the admission and provided before discharge from hospital. - Back, leg, arm and neck support;

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
		- Crutches; - Surgical footwear (excluding health footwear); - Elastic stockings; - Oxygen, diabetic and stoma aids continually essential for the medical treatment of the patient; and - Medical apparatus continually essential for the medical treatment of the patient.
3.2.14 Pathology during hospitalisation	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules underlined by PMB regulations, and shall be paid at cost.	Benefits shall be at 100% of Scheme tariff/cost*.
3.2.15 Basic radiology during hospitalisation	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules underlined by PMB regulations, and shall be paid at cost.	Benefits shall be at 100% of Scheme tariff/cost*.

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
3.2.16 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 limited to the treatment of certain PMB conditions as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules underlined by PMB regulations, and shall be paid at cost.	Benefits shall be at 100% of Scheme tariff/cost* limited to a combined in and out of hospital benefit of R18 000 per family per financial year, subject to the following: - A co-payment of R2 600 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.
3.2.17 Oncology benefits (in or out of hospital) Pre-authorisation must be obtained .	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules underlined by PMB regulations, and shall be paid at cost.	Oncology Programme. Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.
3.2.18 Peritoneal dialysis and haemodialysis (in 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	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	with Annexure D.1 of these Rules underlined by PMB regulations, and shall be paid at cost.	
3.2.19 HIV/AIDS benefits (in or out of hospital) Pre-authorisation must be obtained .	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules underlined by PMB regulations, and shall be paid at cost.	Benefits shall be at 100% of Scheme tariff/cost*, subject to Pre-authorisation and designated or preferred service providers.
3.2.20 Confinements	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, and emergency caesarean sections (C-sections) subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules underlined by PMB regulations, and shall be paid at cost.	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

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
		breastfeeding support shall be excluded from benefits if these are not PMB level of care; and - Midwife assisted births at a private midwife birth house. Transport fees, renting of a birth pool, antenatal consultations, doulas and breastfeeding supports shall be excluded from benefits if these are not PMB level of care.
3.2.21 Refractive surgery and other procedures done to improve or stabilise vision, except for cataracts Pre-authorisation must be obtained.	No benefit, except in respect of PMB conditions	
3.2.22 Supplementary Services during hospitalisation	Benefits shall be limited to the treatment of PMB conditions and DSPs, 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,	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

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	podiatrists/chiropodist, dieticians, speech therapists, biokinetics, stoma therapist and social workers.	therapists, biokinetics, stoma therapist and social workers.
3.2.23 Alternatives to hospitalisation (i.e. procedures done in the doctor's rooms) Pre-authorisation must be obtained.	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules underlined by PMB regulations, and shall be paid at cost.	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.
3.2.24 Advanced illness benefit Pre-authorisation must be obtained.	Benefits shall be limited to the treatment of certain PMB conditions as per the standard of care in the State sector, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules underlined by PMB regulations, and shall be paid at cost.	Benefits shall be at 100% of Scheme tariff/cost* limited to R69 654 per beneficiary per financial year, subject to Pre-authorisation and treatment plan.
3.2.25 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.	

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	- Benefits shall only be payable if the evacuation service was involuntarily requested and delivered by a service provider other than the preferred provider: Provided that services in respect of PMB conditions shall be payable at cost, without deductibles or the use of co-payments, subject to the provisions of Rule 15.10 of the main rules read in conjunction with Annexure D.1 of these Rules, as shall be evaluated by the Scheme.	
3.2.26 International emergency medical cover	In addition to the provisions for foreign claims referred to in Rule 16.12 of the registered Bestmed Rules, the Member and his Dependant(s) qualify for additional benefits which shall be at 100% contracted tariff subject to the following: - Provision of benefits by Europ Assistance SA, as the Scheme's capitated preferred provider for international travel insurance. - Cover for leisure 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 notify to do so will result in claims being rejected.	

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	- General exclusions to services apply. Elective planned procedures undergone outside of South Africa are not covered.	
3.2.27 Day procedures at a day hospital facility	Day procedures at a day hospital facility for PMB conditions. Day procedures for non-PMBs in a network day hospital shall be funded at 100% of Scheme tariff/cost* limited to R54 915 per family per financial year, for the following non-PMB procedures: - Circumcision - Colonoscopy – refer to Rule 3.2.28 for an applicable procedure-specific co-payment - Gastroscopy – refer to Rule 3.2.28 for an applicable procedure-specific co-payment - Myringotomy and grommet insertion - Sterilisation (male and female) - Tonsillectomy Benefits shall be subject to: - Pre-authorisation;	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.

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	- Protocols and funding guidelines; and - DSPs for PMBs 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.	
3.2.28 Co-payments	**Voluntary use of a non-designated Hospital Network co-payment:** A co-payment of R14 364 shall apply on the Rhythm1 and Rhythm2 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.	
	Procedure-specific co-payments The co-payments indicated below shall apply to all procedures, except with respect to a PMB condition: - Colonoscopies - R2 000 - Gastroscopies - R2 000	**Procedure-specific co-payments** The co-payments indicated below shall apply to all procedures, except with respect to a PMB condition: - Arthroscopic procedures - R3 660 - Back and neck surgery - R3 660 - Laparoscopic procedures - R3 660

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	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.	- 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.

3.3. MEDICINE BENEFITS

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

- Prior application and approval by the Scheme where indicated.
- The Scheme treatment protocols and clinical funding guidelines. Motivations and reports by appropriate medical practitioners may be requested by the Scheme.
- The Scheme's formulary (medicine list), where applicable.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
- Where medicines have generic alternatives registered with the South African Health Products Regulatory Authority (SAHPRA), the Scheme will reimburse those medicines up to the MRP for that active ingredient. - Benefit amount for medicine will be calculated at Single Exit Price (SEP), plus the dispensing fee as negotiated by the Scheme, plus VAT. - DSPs may apply - Members choosing the Network options are required to make use of Scheme-contracted pharmacies to obtain their medicine. - Each prescription or repeat prescription shall be limited to one month's supply per beneficiary. The Scheme may, at its sole discretion and according to the relevant protocols, grant an advance supply of medicine upon receipt of the relevant application.		
3.3.1 Chronic medicine not listed on the chronic disease list ("non-CDL medicine")	No benefit	
3.3.2 Medicine for PMB conditions including the conditions listed on the chronic disease list (CDL)	Medicine on the formulary shall be covered at 100% of Scheme tariff/cost* with no co-payment and voluntary use of non-formulary medicine shall be covered at 70% of Scheme tariff with a 30% co-payment. Benefits are subject to prior application and approval by the Scheme.	
3.3.3 Biological 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.	
3.3.4 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	

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations, shall be paid at cost.	
3.3.5 Acute medicine	Benefits shall be at 100% of Scheme tariff, for: - Medicine on the formulary prescribed out of a hospital by a medical practitioner, a dentist or a person authorised thereto by law. - Certain formulary medicines may be subject to annual quantity limits. - No benefit shall apply to non-formulary acute medicine.	
3.3.6 Over-the-counter (OTC) medicine	Benefits shall be at 100% of Scheme tariff up to the limit of R240 per family per annum, limited to R120 per event, at a preferred provider pharmacy network. Benefit includes purchases of sunscreen, vitamins and minerals with nappi codes on the Scheme's formulary.	Benefits shall be at 100% of Scheme tariff up to the limit of R350 per family per annum, limited to R120 per event, at a preferred provider pharmacy network. Benefit includes purchases of sunscreen, vitamins and minerals with nappi codes on the Scheme's formulary.
3.4. PREVENTATIVE CARE AND WELLNESS BENEFITS	Benefits shall be at 100% of Scheme tariff and DSPs or preferred providers.	
3.4.1 Influenza vaccine	1 (one) vaccine per beneficiary per financial year.	
3.4.2 Pneumonia Programme	Children under 2 (two) years of age: - As per the schedule of the Department of Health. Adult group:	

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	- Twice in a lifetime, with a booster if beneficiary is above 65 (sixty-five) years of age. - The Scheme in accordance with its protocol, will identify certain high-risk individuals who will be advised to be immunised.	
3.4.3 Travel vaccinations	Bestmed provides cover for certain mandatory travel vaccines for typhoid, yellow fever, tetanus, meningitis, hepatitis and cholera from Scheme risk benefits.	
3.4.4 Paediatric immunisations	Paediatric vaccines according to the State recommended programme for babies and children.	
3.4.5 Baby growth and development assessments	Children from 0 (zero) up to 2 (two) years of age: - 3 (three) assessments per year. - Assessments must be conducted at a pharmacy clinic or by a registered nurse.	
3.4.6 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 category of female contraceptives. - Intrauterine device (IUD) – insertion (consultation and procedure) of the device if done by a Network gynaecologist or Network 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 200 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 Network gynaecologist or Network GP once every 5 (five) years.
3.4.7 Mammogram	Females 40 (forty) years and older - once every 24 (twenty-four) months. - Only for tariff code 34100; and	

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	- Must be referred by a Rhythm Network GP or a specialist that is part of the Rhythm Specialist Network.	
3.4.8 Human Papilloma Virus (HPV) vaccinations	No benefit.	Females 9 (nine) – 26 (twenty-six) years of age: - 3 (three) vaccinations per beneficiary. - Cervarix/Gardasil shall be funded at Mediscor Reference Price (MRP).
3.4.9 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 a DSP urologist or Rhythm Network GP. Urologist/GP consultation paid from the consultation benefit.
3.4.10 PAP smear: Tariff codes claimed by pathologists or nappi codes claimed by pharmacies in respect of this benefit are included.	Preventative benefit is subject to: - Females 18 (eighteen) years and older. - Once every 24 (twenty-four) months per beneficiary for PAP smear tariff code 4566 or 4559. - To be done at a DSP gynaecologist or Rhythm Network GP. - Consultation fee paid from the available GP consultation benefit or Specialist visits benefit.	
3.4.11 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	

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	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. 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.	
3.5 MATERNITY BENEFITS	Benefits shall be at 100% of Scheme tariff at Network Providers or DSPs only for the following: Consultations:	Benefits shall be at 100% of Scheme tariff at Network Providers or DSPs only for the following: Consultations: - 9 (nine) antenatal consultations at either a GP/gynaecologist/midwife.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	- 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.	- 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.
3.6 OPTOMETRY BENEFITS	Optometry benefits are available per beneficiary every 24 (twenty-four) months from the date of service. Services rendered by the designated optical network, Preferred Provider Negotiators (PPN), optometrists shall be payable at 100% of contracted fee. Services rendered by a non-network provider shall be paid at 100% Scheme tariff subject to the maxima indicated.	
	Benefits from a PPN optometrist shall be as follows: - Consultations: 1 (one) per beneficiary at 100% of cost	Benefits from a PPN optometrist shall be as follows: - Consultations at a network provider: 1 (one) per beneficiary at 100% of cost

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	- No benefits for spectacle frames or lens or contact lenses Benefits from a non-network provider shall be as follows: - Consultations: 1 (one) per beneficiary limited to R400 - No benefits for spectacle frames or lens or contact lenses	- Spectacle frames or lens enhancements limited to R295 AND - Lenses: standard lenses (i.e. single vision or bifocal or multifocal lenses) at 100% of cost OR - In lieu of glasses Members can opt for contact lenses, limited to R770
3.7 OUT-OF-HOSPITAL BENEFITS	- No Personal Medical Savings Account. - Full cross subsidisation between Members shall apply without an annual limit. - Benefits may be subject to the annual maxima for the Member with his Dependant(s) and/or as provided for on the benefit. - The Scheme designated health care providers to provide primary healthcare services/day-to-day services to Members through the Bestmed Rhythm Network. Members may only visit service providers registered on the Rhythm Network.	
3.7.1 GP Consultations Consultations, visits, diagnostic examinations, injections with General Practitioners (GPs).	Benefits shall be at 100% of Scheme tariff/cost* for consultations per family, visits and treatments by GPs registered on the Rhythm Network for the following:	Benefits shall be at 100% of Scheme tariff/cost* for consultations per family, visits and treatments by GPs registered on the Rhythm Network for the following:

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	- Unlimited medically necessary consultations for basic primary care. Pre-approval is required after the 10th (tenth) visit.	- Unlimited medically necessary consultations for basic primary care; and - Specified minor trauma treatment, including stitches, excision and repair, drainage of abscess and limb cast.
3.7.2 Pharmacy clinic nurse consultations	Benefits shall be at 100% of Scheme tariff/cost* for unlimited primary care nurse consultations (nappi code 981078001) at network pharmacies.	No benefit.
3.7.3 Out-of-network or casualty visits	No benefit, except in respect of PMB conditions.	Every family qualifies for out-of-network GP and casualty visits: - Benefits shall be at 100% of Scheme tariff/cost* limited to R1 723 per family per year. - All radiology and pathology investigations at the casualty unit, that fall within the primary care radiology and pathology benefit schedule, as well as medicine costs will be included in this limit. - In the event where the family elects to utilise State facilities for emergency visits, such emergency visits shall be unlimited, in addition to the benefits to which the family is already entitled.

* As per the provisions of Rule 3.1.8.

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
		- The Member shall pay for the visit first and then claim back from the Scheme.
3.7.4 Specialist visits	Benefits shall only be considered if referred by a Rhythm Network GP or a specialist registered on the Rhythm Specialist Network or a PPN provider to a specialist on the Rhythm Specialist Network and shall be subject to the following: - Pre-approval by the Scheme; - The Scheme treatment protocol and clinical funding guidelines (which includes minor procedures done in specialist rooms and all consumable used); and - Limited to R2 553 per family per financial year.	Benefits shall only be considered if referred by a Rhythm Network GP or a specialist registered on the Rhythm Specialist Network or a PPN provider to a specialist on the Rhythm Specialist Network and shall be subject to the following: - Pre-approval by the Scheme; - The Scheme treatment protocol and clinical funding guidelines (which includes minor procedures done in specialist rooms and all consumable used); and - Benefits shall be at 100% of Scheme tariff limited to the following maxima per financial year: M = R1 742 and M1+= R2 903
3.7.5 Basic and specialised dentistry	Benefits shall be at 100% of Scheme tariff per financial year when clinically appropriate, subject to a designated service provider, the Rhythm Dental Network approved tariff list and conditions, as well as the following provisions:	Benefits shall be at 100% of Scheme tariff when clinically appropriate, subject to a designated service provider, the Rhythm Dental Network approved tariff list and conditions, as well as the following provisions:

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
	- 1 (one) consultation for full mouth examination per beneficiary per financial year, subject to the Scheme's list of dental codes; - Preventative treatment once per beneficiary per financial year including scaling, polishing treatment and fillings as per protocol; - Primary extractions if clinically necessary; - No benefits shall apply for dentures; and - No benefits shall apply for specialised dentistry.	- 2 (two) consultations for full mouth examination per beneficiary per financial year, subject to the Scheme's list of dental codes; - Extractions if clinically necessary; - Preventative treatment once every 6 (six) months per beneficiary including scaling and polishing and fluoride treatment; - 1 (one) set of dentures per family per 24 (twenty-four) months. Benefits shall be subject to the use of accredited dental laboratories; and - No benefits shall apply for specialised dentistry.
3.7.6 Medical aids, apparatus and appliances, including wheelchairs and hearing aids.	No benefit, except in respect of PMB conditions.	
3.7.7 Supplementary services Benefits include services rendered by physiotherapists, masseurs, chiropractors, osteopaths, orthoptists, audiologists/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, dieticians, speech	No benefit, except in respect of PMB conditions.	

HEALTHCARE SERVICES	RHYTHM1	RHYTHM2
therapists, biokinetics, private nursing (stoma therapy nursing, obtaining of specimen, observations and administration of medication, immunisations and IV's), psychiatric treatment, psychologists, social workers, homeopaths and acupuncture.		
3.7.8 Wound care benefit Includes dressings and negative pressure wound therapy (NPWT) treatment and nursing services out of hospital.	No benefit, except in respect of PMB conditions.	
3.7.9 Basic radiology and pathology	Standard diagnostic imaging and pathology services requested by a Rhythm Network GP at 100% of Scheme tariff, subject to the following: - Standard diagnostic imaging according to a list of codes approved by the Scheme; and - Basic pathology according to a list of codes approved by the Scheme and subject to the Bestmed Pathology Network.	
3.7.10 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	RHYTHM1	RHYTHM2
	Based on the first assessment, a rehabilitation treatment plan is drawn up and initiated over an uninterrupted period that will be specified by the provider.	
3.7.11 Rehabilitation after trauma Benefits for rehabilitation shall be aimed at the recovery of impeded vital functions immediately after trauma such as a stroke or heart attack.	Benefits shall subject to the following: - Pre-authorisation; - Preferred providers or DSPs; - The treatment of certain PMB conditions, as per the standard of care in the State sector shall be paid at cost, subject to the provisions of Rule 15.10 of the main rules read with Annexure D.1 of these Rules as per PMB regulations.	