COMPARATIVE GUIDE

2027

bestMed

personally yours

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Why choose Bestmed?

Bestmed is *Personally Yours*

- **Excellent preventative care benefits** on all options to ensure the early detection of serious illness or medical conditions
- Children qualify for **child dependant rates up to the age of 24 years**
- Families pay for up to three child beneficiaries and the **rest are covered at no cost (All options except Rhythm1)**
- **Extensive maternity benefits,** including a maternity care programme
- **Eight Managed Healthcare programmes,** including Back and neck preventative programme, Oncology care, HIV/AIDS care, Dialysis care, Alcohol and Substance Abuse care, Wound care, Stoma care and Maternity care
- Bestmed is the **largest self-administered scheme** which means that administration costs are less than our competitors
- Bestmed is the **fourth largest open medical scheme** in the country
- Ranked at the **forefront of customer experience** in the medical schemes industry in the **2020, 2021 and 2022 South African Customer Satisfaction Index (SA-csi),** and rated **first** in the Medical Aid Companies category of the **Ask Africa Orange Index** in 2020, 2022 and 2026. Bestmed was also honoured as the **News24 Medical Scheme of the Year** in the **News24 Business Awards 2024**
- Bestmed is the only open medical scheme in the top 5 schemes that achieved positive growth for 7 consecutive years
- **Over 19 360 network providers** across South Africa

Access our FREE Tempo wellness programme

- Live life at your Tempo with free health and wellness benefits for all beneficiaries, regardless of your benefit option
- The Tempo Lifestyle Screening, available online for your convenience, will help you assess your overall health and wellness status
- Fully funded in-person and/or virtual consultations with Bestmed Tempo partner biokineticists and dietitians
- An established network of healthcare professionals supporting your physical, nutritional and mental wellbeing

Be 'appy' and download the Bestmed App

The **Bestmed App** is just one more way that Bestmed is *Personally Yours*. It's user-friendly and has been designed to put all your essential medical aid information at your fingertips.

The app provides the following benefits:

- A digital version of your membership card
- Find a service provider near you
- Submit a claim
- Check your available benefits
- Email your membership card to service providers
- Check your Tempo Lifestyle Screening results
- Update contact details for dependants 18 years and older
- Submit your chronic application / prescription

Download the Bestmed App from your preferred platform:

Google Play Store
Android devices

App Store
iOS devices

AppGallery
Huawei devices

BEST BUCKS

Best Bucks Benefit

What if completing a routine health check unlocked actual funds that pay for your next doctor's visit? Well, with Best Bucks and the Tempo Lifestyle Screening, it does! Here's what you need to know.

WHAT IS BEST BUCKS?

Best Bucks is an additional Bestmed benefit of R1 000 per family that members receive over and above their annual day-to-day and/or savings benefits, and that is used for out-of-hospital claims.

Best of all, all qualifying out-of-hospital claims are paid from your Best Bucks first, before your annual day-to-day and/or personal medical savings account (PMSA).

WHICH OUT-OF-HOSPITAL CLAIMS ARE PAID FROM THE BEST BUCKS?

- GP and specialist consultations
- Radiology
- Pathology
- Over-the-counter medication
- Acute medicine
- Supplementary services such as mental health, dietitians, biokineticists consultations, etc.

HOW DO I UNLOCK MY BEST BUCKS?

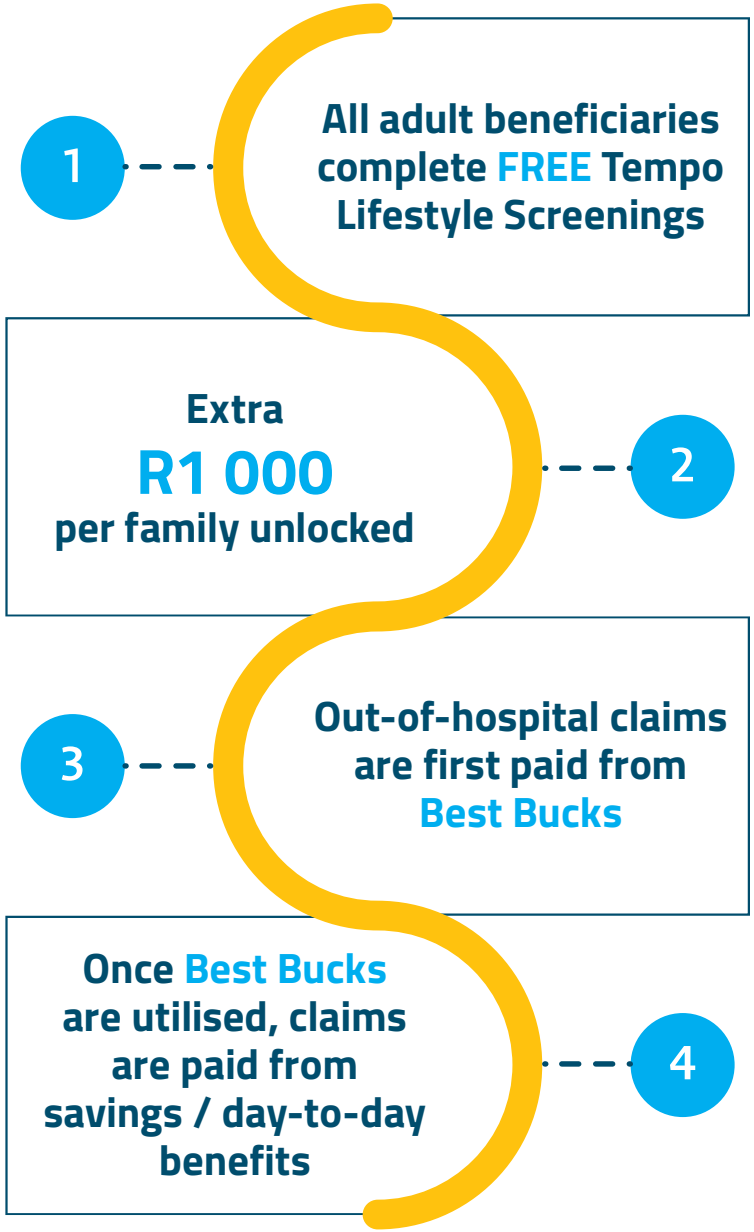
To activate this extra benefit, all adult beneficiaries registered on your Bestmed membership must complete their free Tempo Lifestyle Screening at a Tempo network pharmacy, Tempo network GP, Tempo partner dietitian, or Tempo partner biokineticist. The list of service providers can be found on www.bestmed.co.za under Tempo wellness programme.

Once the Tempo Lifestyle Screening is done and the results are submitted to Bestmed, your Best Bucks will automatically be activated.

IMPORTANT:

- Claims are paid at 100% Scheme tariff from the Best Bucks.
- Co-payments or shortfalls cannot be paid from the Best Bucks.
- Best Bucks is not available on the Beat1, Beat1 Network, Rhythm1 and Rhythm2 options.

Product rules, limits, terms and conditions apply. Where there is a discrepancy between the content provided herein and the Scheme Rules, the Scheme Rules will prevail.



TEMPO

All you need to know about Tempo

WHAT IS TEMPO?

Tempo is our health and wellness programme that assists members in leading a healthier lifestyle and living their best lives.

WHY SHOULD I ACTIVATE TEMPO?

As a member, you and your family already have access to the Tempo benefits at no additional costs. By simply completing the Tempo Lifestyle Screening, you activate Tempo benefits and you will automatically have access to over a thousand healthcare professionals who are trained and motivated to help you improve your lifestyle and become the best version of yourself.

HOW DO I ACTIVATE THE PROGRAMME?

For your convenience the Tempo Lifestyle Screening is available for completion via the Tempo portal on the Bestmed App. Your data will reflect on the Tempo partner pharmacies' (Clicks, Dis-Chem, Van Heerden Pharmacy, Arrie Nel, and The Local Choice) systems for the registered nurse to also complete the biometric portion of the screening. The biometric portion of the Tempo Lifestyle Screening can also be completed at a Tempo network GP, Tempo partner dietitian, or Tempo partner biokineticist. The list of service providers can be found on **www.bestmed.co.za** under Tempo wellness programme. The completed screening will give you an important overview of your health status, and guide you in areas to improve your health.

WHAT ARE THE BENEFITS OF THE TEMPO WELLNESS PROGRAMME?

The Tempo wellness programme is focused on supporting you on your path to improving your health and realising the rewards that come with it. To ensure you achieve this, you will have access to the following benefits:

Tempo Lifestyle Screening for adults (beneficiaries 16 years and older) which includes:

- The Tempo lifestyle questionnaire
- Blood pressure check
- Cholesterol check (finger prick)
- Glucose check (finger prick)
- Height and weight measurement

Once all adult beneficiaries have completed their Tempo Lifestyle Screening, the Best Bucks benefit is unlocked on all benefit options except Beat1, Beat1 Network, Rhythm1 and Rhythm2.

Tempo physical wellbeing and nutrition benefits (beneficiaries 16 and older):

Physical wellbeing:

- 1 x **(face-to-face)** physical health assessment at a Tempo partner biokineticist
- 1 x follow-up **(virtual or face-to-face)** consult to obtain your personalised exercise plan from the Tempo partner biokineticist

Remember that these physical wellbeing consultations are FREE once you have completed your Tempo Lifestyle Screening.

Nutrition:

- 1 x **(face-to-face)** nutrition assessment at a Tempo partner dietitian
- 1 x follow-up **(virtual or face-to-face)** consult to obtain your personalised healthy-eating plan from the Tempo partner dietitian

Remember that these nutritional wellbeing consultations are FREE once you have completed your Tempo Lifestyle Screening. In addition to the Tempo physical wellbeing and nutrition benefits, you will also have access to **Tempo Wellness Webinars** hosted monthly. The webinars are themed around mental health and various other wellness-related topics.

DO THE FREE BENEFITS DIFFER FOR MEMBERS ON DIFFERENT HEALTHCARE OPTIONS?

No. The Bestmed Tempo benefits are exactly the same on all the options.

We hope you found the answer you were looking for. If not, please email us for more information: **tempo@bestmed.co.za**

*All beneficiaries need to register their details on the Tempo portal to use the online features, and cannot register with the principal member's details.

bestMed tempo wellness programme

BEAT

The Beat range offers flexible hospital benefits with a personal medical savings account (PMSA) on some options to pay for out-of-hospital expenses. Beat1, 2 and 3 also offer you the choice to lower your monthly contribution in the form of network options.

Method of Scheme benefit payment

BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
▪ In-hospital benefits are paid from Scheme risk. ▪ Some preventative care benefits are available from Scheme risk. ▪ Out-of-hospital benefits are paid from your own pocket.	▪ In-hospital benefits are paid from Scheme risk. ▪ Some preventative care benefits are available from Scheme risk. ▪ Out-of-hospital benefits are paid from your personal medical savings account (PMSA).	▪ In-hospital benefits are paid from Scheme risk. ▪ Some preventative care benefits are available from Scheme risk. ▪ Some out-of-hospital benefits are paid from Scheme risk and some from your personal medical savings account (PMSA).		▪ In-hospital benefits are paid from Scheme risk. ▪ All preventative care benefits are available from Scheme risk. ▪ Out-of-hospital benefits are paid from your personal medical savings account (PMSA) first and, once depleted, from your day-to-day benefit.

BEAT NETWORK PLAN OPTIONS

- Bestmed offers members a choice of network hospitals for in-hospital benefits.
- If a member voluntarily chooses not to make use of a hospital within the Beat network, a maximum co-payment of R15 626 will apply.

In-hospital benefits

The non-network (standard) Beat options provide you with access to any hospital of your choice. The network options provide you with a list of designated hospitals for you to use and also allows you to save.

Benefits relating to conditions that meet the criteria for PMBs will be covered in full when using DSPs, and this will not affect your personal medical savings account (PMSA).

Note: All the below benefits are subject to pre-authorisation and clinical protocols.

All members must obtain pre-authorisation for planned procedures at least 14 (fourteen) days before the event. However, in the case of an emergency, you, your representative or the hospital must notify Bestmed of your hospitalisation as soon as possible or on the first working day after admission to hospital.

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Accommodation (hospital stay) in a general ward, intensive care and high-care unit, theatre and material	Benefits shall be at 100% of Scheme tariff. Network options: DSP Network applies.				
To-take-out (TTO) / Take-home medicine	Benefit shall be at 100% Scheme tariff if claimed on the day of discharge, as follows: Up to 7 days treatment if claimed as part of the hospital account, or up to R468 if claimed from a retail pharmacy. Subject to MediKredit Reference Price (MMAP). No benefit if not claimed within 3 days from the date of discharge.		Benefit shall be at 100% Scheme tariff if claimed on the day of discharge, as follows: Up to 7 days treatment if claimed as part of the hospital account, or up to R520 if claimed from a retail pharmacy. Subject to MediKredit Reference Price (MMAP). No benefit if not claimed within 3 days from the date of discharge.		Benefit shall be at 100% Scheme tariff if claimed on the day of discharge, as follows: Up to 7 days treatment if claimed as part of the hospital account, or up to R572 if claimed from a retail pharmacy. Subject to MediKredit Reference Price (MMAP). No benefit if not claimed within 3 days from the date of discharge.
Biological medicine during hospitalisation	Benefits shall be at 100% Scheme tariff up to R12 630 per family per annum. Subject to pre-authorisation and funding guidelines.	Benefits shall be at 100% Scheme tariff up to R18 944 per family per annum. Subject to pre-auhorisation and funding guidelines.	Benefits shall be at 100% Scheme tariff up to R25 257 per family per annum. Subject to pre-authorisation and funding guidelines.		Benefits shall be at 100% Scheme tariff up to R31 571 per family per annum. Subject to pre-authorisation and funding guidelines.

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Treatment in mental health facilities	Benefits shall be at 100% Scheme tariff. Up to 21 days per beneficiary per annum in hospital, including inpatient electro-convulsive therapy and inpatient psychotherapy, OR 15 contact sessions for out-patient psychotherapy per beneficiary per annum. Subject to pre-authorisation and DSPs.				
Treatment of chemical and substance abuse Please refer to the Managed Care Guide	Benefits shall be limited to the treatment of PMB conditions and subject to the following: ▪ Pre-authorisation. ▪ DSPs. ▪ Up to 21 days' stay for in-hospital management per beneficiary per annum.				
Consultations and procedures	Benefits shall be at 100% Scheme tariff for claims submitted by General Practitioners (GPs) and specialists for treatment during hospitalisation.				
Surgical procedures and anaesthetics	Benefits shall be at 100% Scheme tariff.				
Supplementary services during hospitalisation	Benefits shall be at 100% Scheme tariff, 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, orthoptists, audiologists / hearing aid acousticians, occupational therapists, podiatrists /chiropodist, dietitians, speech therapists, biokineticists, stoma therapist and social workers.				
Organ transplants (in and/or out of hospital)	Benefits limited to PMBs only at DSPs.				
Stem cell transplants (in and/or out of hospital)	Benefits limited to PMBs only at DSPs.				
Blood transfusion	Benefits shall be at 100% Scheme tariff for blood, operators' fees, transport charges and apparatus.				
Pathology	Benefits shall be at 100% Scheme tariffs.				
Basic radiology	Benefits shall be at 100% Scheme tariffs.				
Specialised diagnostic imaging and nuclear medicine - in and/or out of hospital (including MRI scans, CT scans and nuclear / isotope studies). PET scans only included as indicated per benefit option	Benefits shall be at 100% Scheme tariff. Up to a combined in- and out-of-hospital benefit of R21 757 per family per annum. PET scans - PMB only. Subject to benefit confirmation and reference number received from the Scheme.	Benefits shall be at 100% Scheme tariff. Up to a combined in- and out-of-hospital benefit of R23 932 per family per annum. PET scans - PMB only. Subject to benefit confirmation and reference number received from the Scheme.	Benefits shall be at 100% Scheme tariff. Up to a combined in- and out-of-hospital benefit of R34 811 per family per annum. PET scans - PMB only. Subject to benefit confirmation and reference number received from the Scheme.	Benefits shall be at 100% Scheme tariff. Up to a combined in- and out-of-hospital benefit of R38 074 per family per annum. PET scans - PMB only. Subject to benefit confirmation and reference number received from the Scheme.	Benefits shall be at 100% Scheme tariff. Up to a combined in- and out-of-hospital benefit of R43 514 per family per annum. PET scans are limited to one (1) scan per beneficiary per annum. Subject to benefit confirmation and reference number received from the Scheme.

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Dental and oral surgery (in and/or out of hospital subject to pre-authorisation)	Benefits limited to PMBs only at DSP day hospitals.	**Benefits limited to PMBs only at DSP day hospitals.** **Beneficiaries 7 years and younger, and beneficiaries with disabilities:** Up to R6 908 per family per annum for the following procedures at DSP day hospital: ▪ Fillings. ▪ Extractions. ▪ Pulp procedures. **Beneficiaries over 7 years** Selected surgical procedures paid from personal medical savings account (PMSA) and performed in-rooms only.	**Benefits shall be at 100% Scheme tariff up to R10 626 per family per annum in or out of hospital:** ▪ Surgical extractions of teeth / roots / impactions / failed implants. ▪ Surgical drainage of dental abscess. ▪ Surgical removal of jaw cyst. ▪ Apicoectomy (root canal-related surgery). **Beneficiaries 7 years and younger, and beneficiaries with disabilities** The following procedures performed under sedation at a DSP day hospital and will be covered from the personal medical savings account (PMSA) at 100% Scheme tariff: ▪ Pulp procedures. ▪ Extractions. ▪ Restorations (fillings). **The following procedures will be covered from the personal medical savings account (PMSA) at 100% Scheme tariff:** ▪ Implant placements. ▪ Bone augmentation (preparatory surgery for dental prosthesis).		**Benefits shall be at 100% Scheme tariff up to R13 283 per family per annum in or out of hospital:** ▪ Surgical extractions of teeth / roots / impactions / failed implants. ▪ Surgical drainage of dental abscess. ▪ Surgical removal of jaw cyst. ▪ Apicoectomy (root canal-related surgery). ▪ Orthognathic surgery. ▪ Bone augmentation (preparatory surgery for dental prosthesis). **Beneficiaries 7 years and younger, and beneficiaries with disabilities** The following procedures performed under sedation at a DSP day hospital and will be covered from the personal medical savings account (PMSA) at 100% Scheme tariff: ▪ Pulp procedures. ▪ Extractions. ▪ Restorations (fillings). **The following procedures will be covered from the personal medical savings account (PMSA) at 100% Scheme tariff:** ▪ Implant placements.
Major maxillofacial surgery limited to surgical procedures that fall under the scope of maxillofacial surgeons (Subject to pre-authorisation)	Benefits limited to PMBs only at DSP day hospitals.		Benefits shall be at 100% Scheme tariff. Up to R17 033 per family per annum, including TMJ procedures: ▪ Arthrocentesis. ▪ Arthroplasty.		Benefits shall be at 100% Scheme tariff. Up to R17 345 per family per annum, including TMJ procedures: ▪ Arthrocentesis. ▪ Arthroplasty.

	BEAT1 BEAT2	BEAT3 BEAT3 PLUS	BEAT4
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 **Note:** Sub-limits subject to availability of overall prosthesis limit. DSPs apply Overall annual prosthesis limit (subject to preferred providers and DSPs, otherwise limits and co-payments apply) *Functional: items used to replace or augment an impaired bodily function	Benefits shall be paid at 100% Scheme tariff up to R103 755 per family per annum. Sub-limits per beneficiary per annum: ▪ *Functional R37 038. ▪ Vascular R59 739. ▪ Pacemaker (single and dual chamber) R56 566. ▪ Spinal including artificial disc R41 412. ▪ Drug-eluting stents – subject to Vascular prosthesis limit. ▪ Mesh R14 534. ▪ Gynaecology / urology R11 876. ▪ Lens implants R9 062 a lens per eye. ▪ Endovascular and catheter-based procedures - subject to Vascular prosthesis limit.	Benefits shall be paid at 100% Scheme tariff up to R104 851 per family per annum. Sub-limits per beneficiary per annum: ▪ *Functional R38 234. ▪ Vascular R71 686. ▪ Pacemaker (single and dual chamber) R56 566. ▪ Spinal including artificial disc R41 565. ▪ Drug-eluting stents – subject to Vascular prosthesis limit. ▪ Mesh R14 609. ▪ Gynaecology / urology R12 065. ▪ Lens implants R9 062 a lens per eye. ▪ Endovascular and catheter-based procedures - subject to Vascular prosthesis limit.	Benefits shall be paid at 100% Scheme tariff up to R127 987 per family per annum. Sub-limits per beneficiary per annum: ▪ *Functional R40 622. ▪ Vascular R77 661. ▪ Pacemaker (single and dual chamber) R74 067. ▪ Spinal including artificial disc R44 223. ▪ Drug-eluting stents R24 846. ▪ Mesh R16 408. ▪ Gynaecology / urology R12 033 ▪ Lens implants R9 375 a lens per eye. ▪ Endovascular and catheter-based procedures - subject to Vascular prosthesis limit.
Exclusions on joint replacement surgery for non-PMB conditions (Prosthesis sub-limits form part of overall Internal prosthesis limit subject to preferred provider, otherwise limits and co-payments apply)	Joint replacement surgery excluded (except for PMBs). PMBs subject to prosthesis limits: ▪ Hip replacement and other major joints R43 595. ▪ Knee and shoulder replacements R53 753. ▪ Other minor joints R16 721.	Joint replacement surgery excluded (except for PMBs). PMBs subject to prosthesis limits: ▪ Hip replacement and other major joints R43 910. ▪ Knee and shoulder replacements R54 331. ▪ Other minor joints R16 721.	Joint replacement surgery excluded (except for PMBs). PMBs subject to prosthesis limits: ▪ Hip replacement and other major joints R45 472. ▪ Knee and shoulder replacements R60 409. ▪ Other minor joints R18 562.
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	Benefits limited to PMBs only.		Benefits shall be at 100% Scheme tariff up to R30 783 per family. Includes artificial limbs, up to one (1) limb every 60 months. Repair work to artificial limbs will be funded from the out-of-hospital Medical aids, apparatus and appliances benefit.
Orthopaedic and medical appliances **Note:** Appliances directly relating to the hospital admission and/or procedure	Benefits shall be at 100% Scheme tariff up to R16 318 per family per annum for medically necessary appliances for back, leg, arm and neck support, crutches, surgical footwear and elastic stockings directly related to the admission and provided before discharge from hospital.		Benefits shall be at 100% Scheme tariff up to R18 000 per family per annum for medically necessary appliances for back, leg, arm and neck support, crutches, surgical footwear and elastic stockings directly related to the admission and provided before discharge from hospital.

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Oncology (in and/or out of hospital) Please refer to the Managed Care Guide	Benefits shall be at 100% Scheme tariff, subject to pre-authorisation, designated or preferred service providers, and protocols. Essential ICON protocols apply.				
Breast surgery for cancer	Treatment of the **unaffected (non-cancerous) breast** will be limited to PMB provisions and is subject to pre-authorisation and funding guidelines.				
Peritoneal dialysis and haemodialysis (in and/or out of hospital) Please refer to the Managed Care Guide	Benefits shall be at 100% Scheme tariff. Subject to pre-authorisation and designated or preferred service providers.				
Confinements (birthing, including midwife-assisted births)	Benefits shall be at 100% Scheme tariff for: ▪ 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. ▪ 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.				
HIV/AIDS benefits (in and/or out of hospital) Please refer to the Managed Care Guide	Benefits shall be at 100% Scheme tariff. Subject to pre-authorisation and designated or preferred service providers, with LifeSense as the Managed care organisation.				
Refractive surgery and other procedures (in and/or out of hospital) done to improve or stabilise vision (except cataracts)	Benefits limited to PMBs only.		Benefit shall be at 100% Scheme tariff. Subject to pre-authorisation and protocols. Up to R10 939 per eye.		Benefit shall be at 100% Scheme tariff. Subject to pre-authorisation and protocols. Up to R12 346 per eye.
Corneal cross-linking	Benefits shall be at 100% Scheme tariff per beneficiary for clinically appropriate treatment of corneal conditions (e.g. keratoconus). Subject to pre-authorisation.				
Alternative 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.				
Cochlear implants and bone anchored hearing aids (BAHA) implants (including fees for all providers, hospital and device)	Benefits limited to PMBs only.				Benefits shall be at 100% Scheme tariff up to a maximum limit of R250 000 per beneficiary per annum. Subject to pre-authorisation and Preferred Providers or DSPs. Sound processor upgrades every 5 years.
Varicose veins procedure in hospital	Not applicable to benefit option.		Benefit shall be at 100% Scheme tariff for the treatment of varicose veins performed in a hospital. Subject to pre-authorisation and day hospital rules and funding guidelines.		

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Advanced illness benefit	Benefits shall be at100% Scheme tariff, up to R75 772 per beneficiary per annum. Subject to available benefit, pre-authorisation and treatment plan.				Benefits shall be at 100% Scheme tariff, up to R113 660 per beneficiary per annum. Subject to available benefit, pre-authorisation and treatment plan.
Day procedures at a day hospital facility	Day procedures performed in a day hospital by a DSP provider will be funded at 100% network or Scheme, subject to: pre-authorisation; protocols and funding guidelines; and DSPs. Please refer to Day Procedure List on page 53. A co-payment of R2 987 will 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 day procedure co-payment will not apply if done in acute hospital, if it is arranged with the Scheme before the time.				
Co-payments	**Non-network hospital co-payment:** Co-payment for voluntary use of non-network hospital R15 626. Applicable to network options.			No non-network co-payments applicable.	
Ambulance and emergency evacuation services	Benefits shall be subject to provisions of benefits by Netcare 911, as the Scheme's capitated preferred provider for ambulance services. Benefits shall only be payable if the evacuation service was involuntarily requested and delivered by a service provider other than the preferred provider: Provided that services in respect of PMB conditions shall be payable at cost, without deductibles or the use of co-payments, subject to the provisions of Scheme Rules. Authorisation needs to be obtained directly from Netcare 911.				
International medical travel cover	▪ **Holiday travel:** Up to 90 days and R5 000 000 per family, i.e. members and dependants. Limited to R1 000 000 per family for travel to the USA. ▪ **Business travel:** Up to 60 days and R5 000 000 per family, i.e. members and dependants. Limited to R1 000 000 per family for travel to the USA.				

Out-of-hospital benefits

Note: Benefits below may be subject to pre-authorisation, clinical protocols, preferred providers, designated service providers (DSPs), formularies, funding guidelines and the MediKredit Reference Price (MMAP).

Members are required to obtain pre-authorisation for all planned treatments and/or procedures, PMB services and chronic medication.

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Overall day-to-day limit	Not applicable to benefit option.				Maximum limits per annum: M = R16 876 and M1+ = R33 750.
General Practitioner (GP), nurse and specialist consultations, including consultations, visits, diagnostic examinations, injections and emergency unit visits (where a procedure room was used) with GPs, contracted nursing clinical services, contracted primary care drug therapy (PCDT) pharmacists, specialists, homeopaths and herbalists	Not applicable to benefit option.	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA).			Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA) first. Once the funds in the PMSA have been depleted, benefits shall be subject to the overall day-to-day limit and the following maximum limits per annum: M = R4 298 and M1+ = R7 655.
Emergency room consultations / casualty visits	Not applicable to benefit option.	Benefit shall be at 100% Scheme tariff up to two (2) emergency room (ER) or casualty ward visits per family per annum, up to R3 000 per event. The limits include costs for doctor consultations, facility fees, radiology, pathology and medicine used during the treatment in the ER.			

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Dental benefit Including check-ups, fillings, extractions, root canals, crowns, bridges, dentures, periodontal treatment	Not applicable to benefit option.	Benefits shall be at 100% of Scheme tariff from the personal medical savings account (PMSA): ▪ Prosthodontics services (crowns, bridges, inlays, veneers and dentures). ▪ Periodontics services (gum diseases). ▪ Orthodontic services (correction of malaligned teeth by means of braces, retainers or similar) are subject to pre-authorisation. Covered once per beneficiary per lifetime.			Benefits shall be at 100% Scheme tariff from personal medical saving account (PMSA) first. M= R7 435 and M1+= R14 933 (subject to overall day-to-day limit). ▪ Prosthodontics services (crowns, bridges, inlays, veneers and dentures); ▪ Periodontics services (gum diseases); ▪ Orthodontic services (correction of malaligned teeth by means of braces, retainers or similar) are subject to pre-authorisation. Covered once per beneficiary per lifetime.
General full-mouth examination by a general dentist (incl. gloves and use of sterile equipment)	Not applicable to benefit option.	Once per annum for members 12 years of age and above. Once every six months for members under 12 years (paid from preventative dentistry benefit as per Preventative dentistry table on page 21).			
Full-mouth intra-oral radiographs	Not applicable to benefit option.	Once every 36 months for all ages (paid from preventative dentistry benefit as per Preventative dentistry table on page 21).			
Intra-oral radiograph	Not applicable to benefit option.	Two (2) radiographs per annum for all ages (paid from preventative dentistry benefit as per Preventative dentistry table on page 21).			
Scaling and/or polishing	Not applicable to benefit option.	Once every six months (i.e. every 6 months from the date of service) for all ages (paid from preventative dentistry benefit as per Preventative dentistry table on page 21).			
Fluoride treatment	Not applicable to benefit option.	Once every six months (i.e. every 6 months from the date of service) for all ages (paid from preventative dentistry benefit as per Preventative dentistry table on page 21).			
Fissure sealant	Not applicable to benefit option.	Up to and including 21 years of age (paid from preventative dentistry benefit as per Preventative dentistry table on page 21).			
Space maintainers	Not applicable to benefit option.	Once per beneficiary per annum (paid from preventative dentistry benefit as per Preventative dentistry table on page 21).			

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Medical aids, apparatus and appliances including wheelchairs	Not applicable to benefit option.	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA), for the following: ▪ Back, leg, arm and neck support. ▪ Wheelchairs. ▪ Surgical footwear. ▪ Crutches. ▪ Elastic stockings. ▪ Repair work on artificial limbs, wheelchairs, etc. ▪ Stoma products, oxygen and diabetic supplies for non-PMB conditions.			Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA). Once the funds in the PMSA have been depleted, benefits shall be subject to the overall day-to-day limit and R15 158 per family per annum 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. ▪ Stoma products, oxygen and diabetic supplies for non-PMB conditions.
Hearing aids and repair work on hearing aids (Hearing aids subject to pre-authorisation)	Not applicable to benefit option.	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA). Subject to quotation, motivation and audiogram.			Benefits shall be at 100% Scheme tariff up to R13 891 per family every 24 months. 100% Scheme tariff. Subject to quotation, motivation and audiogram.
Supplementary services Benefits include services rendered by physiotherapists, orthoptists, audiologists / hearing aid acousticians, occupational therapists, podiatrists / chiropodist, dietitians, speech therapists, biokineticists, private nursing (stoma therapy nursing, obtaining of specimen, observations and administration of medication, immunisations and IV's), psychiatric treatment, psychologists and social workers	Not applicable to benefit option.	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA).		Benefits shall be at 100% Scheme tariff and be up to R2 276 per family per annum subject to the use of DSPs. Thereafter, benefit shall be from personal medical savings account (PMSA).	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA). Once the funds in the PMSA have been depleted, benefits shall be at 100% Scheme tariff subject to the overall day-to-day limit and the following maximum limit per annum: M = R6 563 M1+ = R13 330.
Wound care benefit (including dressings, wound therapy, and related nursing services) Please refer to the Managed Care Guide	General wound care therapy shall be at 100% Scheme tariff up to R4 642 per family per annum. Subject to pre-authorisation.				General wound care shall be at 100% Scheme tariff from the personal medical savings account (PMSA). Once the funds in the PMSA have been depleted, benefits shall be at 100% Scheme tariff subject to the overall day-to-day limit and R6 563 per family per annum.

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Negative-pressure wound therapy (NPWT)	Benefit shall be at 100% Scheme tariff. Subject to pre-authorisation based on clinical motivation and an approved treatment plan.				
Varicose veins procedure in rooms Benefits include fees related to the procedure, all providers' fees, facility fees, material and catheters	Not applicable to benefit option.		Benefits shall be at 100% Scheme tariff for the treatment of varicose veins performed in provider rooms. Subject to pre-authorisation and funding guidelines.		
Basic radiology and pathology	Not applicable to benefit option.	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA).			Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA). Once the funds in the PMSA have been depleted, benefits shall be at 100% Scheme tariff subject to the overall day-to-day limit and the following maximum limit per annum: M = R4 297 and M1+ = R8 751.
Specialised diagnostic imaging and nuclear medicine - in and/ or out of hospital (including MRI scans, CT scans and nuclear / isotope studies). PET scans only included as indicated per benefit option	Benefits shall be at 100% Scheme tariff up to a combined in- and out-of-hospital benefit of R21 757 per family per annum. PET scans - PMB only. Subject to benefit confirmation and reference number received from the Scheme.	Benefits shall be at 100% Scheme tariff up to a combined in- and out-of-hospital benefit of R23 932 per family per annum. PET scans - PMB only. Subject to benefit confirmation and reference number received from the Scheme.	Benefits shall be at 100% Scheme tariff up to a combined in- and out-of-hospital benefit of R34 811 per family per annum. PET scans - PMB only. Subject to benefit confirmation and reference number received from the Scheme.	Benefits shall be at 100% Scheme tariff up to a combined in- and out-of-hospital benefit of R38 074 per family per annum. PET scans - PMB only. Subject to benefit confirmation and reference number received from the Scheme.	Benefits shall be at 100% Scheme tariff up to a combined in- and out-of-hospital benefit of R43 514 per family per annum. PET scans are limited to one (1) scan per beneficiary per annum. Subject to benefit confirmation and reference number received from the Scheme.
Rehabilitation services after trauma	Benefit limited to PMBs only. Subject to pre-authorisation and designated or preferred service providers.				Benefits shall be at 100% Scheme tariff.
Back and neck preventative programme Please refer to the Managed Care Guide	Benefits shall be payable at 100% of contracted fee and are applicable to all ages subject to pre-authorisation: ▪ Applicable to beneficiaries with 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.				
HIV/AIDS benefits (in and/or out of hospital) Please refer to the Managed Care Guide	Benefits shall be at 100% Scheme tariff. Subject to pre-authorisation and designated or preferred service providers, with LifeSense as the Managed care organisation.				
Oncology (in and/or out of hospital) Please refer to the Managed Care Guide	Benefits shall be at 100% Scheme tariff, subject to pre-authorisation, designated or preferred service providers, and protocols. Essential ICON protocols apply.				
Peritoneal dialysis and haemodialysis Please refer to the Managed Care Guide	Benefits shall be at 100% Scheme tariff. Subject to pre-authorisation and designated or preferred service providers.				

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Optometry benefit	Not applicable to benefit option.	Benefits shall be paid from the personal medical savings account (PMSA).		Benefits available every 24 months from date of service. **Network Provider (PPN)** Consultation - One (1) per beneficiary. Frame = R1 090 covered AND 100% of cost of standard lenses (single vision OR bifocal OR multifocal) OR Contact lenses = R1 850 OR **Non-network Provider** Consultation - R433 fee at non-network provider Frame = R818 AND Single vision lenses = R230 OR Bifocal lenses = R502 OR Multifocal lenses = R1 110 (consisting of R880 per base lens plus R230 per branded lens add-on) In lieu of glasses members can opt for contact lenses, limited to R1 850.	Benefits available every 24 months from date of service. **Network Provider (PPN)** Consultation - One (1) per beneficiary. Frame = R1 395 covered AND 100% of cost of standard lenses (single vision OR bifocal OR multifocal) OR Contact lenses = R2 190 OR **Non-network Provider** Consultation - R433 fee at non-network provider Frame = R1 046 AND Single vision lenses = R230 OR Bifocal lenses = R502 OR Multifocal lenses = R1 110 (consisting of R880 per base lens plus R230 per branded lens add-on) In lieu of glasses members can opt for contact lenses, limited to R2 190.

Medicine benefits

Note: Benefits mentioned below may be subject to pre-authorisation, clinical protocols, preferred providers, designated service providers (DSPs), formularies, funding guidelines, the MediKredit Reference Price (MMAP), and the exclusions referred to in Annexure C of the registered Rules. Approved Chronic Disease List (CDL), Prescribed Minimum Benefits (PMBs) and non-Chronic Disease List (non-CDL) chronic medicine costs will be paid from the non-CDL chronic medicine limit first. Thereafter, approved CDL and PMB chronic medicine costs will continue to be paid (unlimited) from Scheme risk.

Members will not incur co-payments for approved PMB medications that are on the formulary for which there is no generic alternative.

Note: Refer to the Chronic Conditions List at the back of the Comparative Guide.

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Medicine for PMB conditions including the conditions listed on the chronic disease list (CDL) Subject to pre-authorisation	Benefits shall be at 100% Scheme tariff. A co-payment of 30% applies to non-formulary medicine.				Benefits shall be at 100% of Scheme tariff. A co-payment of 20% applies to non-formulary medicine.
Non-CDL chronic medicine Subject to pre-authorisation	Not applicable to benefit option.		5 conditions. Payment shall be limited to M = R4 532 and M1+ = R9 220 per annum. Medicine on the formulary shall be covered at 80% Scheme tariff with a 20% co-payment and non-formulary medicine shall be covered at 70% Scheme tariff with a 30% co-payment.	6 conditions. Payment shall be limited to M = R4 532 and M1+ = R9 220 per annum. Medicine on the formulary shall be covered at 80% Scheme tariff with a 20% co-payment and non-formulary medicine shall be covered at 70% Scheme tariff with a 30% co-payment.	9 conditions. Payment shall be limited to M = R9 954 and M1+ = R19 909 per annum. 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.

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Medicine for treatment of major depression	Benefits shall be at 100% Scheme tariff subject to: ▪ Restricted to medicine on the formulary. ▪ Up to R160 per beneficiary per month.	Benefits shall be at 100% Scheme tariff subject to: ▪ Restricted to medicine on the formulary. ▪ Up to R180 per beneficiary per month.	Benefits shall be at 100% Scheme tariff subject to: ▪ Restricted to medicine on the formulary. ▪ Up to R200 per beneficiary per month.	Major depression covered as a non-CDL condition. Please refer to page 51.	
Biological medicine	Benefits limited to PMBs only as per funding protocol. Subject to pre-authorisation.				
Other high-cost medicine out of hospital	Benefits limited to PMBs only as per funding protocol. Subject to pre-authorisation.				
Acute medicine	Not applicable to benefit option.	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA) for prescribed medicine, including registered homeopathic remedies, injections and herbal remedies with a NAPPI code.			Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA) for prescribed medicine, including registered homeopathic remedies, injections and herbal remedies with a NAPPI code. Once the funds in the PMSA have been depleted, benefits shall be at 100% Scheme tariff subject to the overall day-to-day limit and the following maximum limit per annum: M = R3 798 and M1+ = R7 671.
Over-the-counter (OTC) medicine Includes sunscreen, vitamins and minerals with NAPPI codes on Scheme formulary	Not applicable to benefit option.	Benefit shall be paid at 100% Scheme tariff from the personal medical savings account (PMSA).			**Member choice: R1 396 OTC limit per family OR access to full savings for OTC purchases (after R1 396 limit) = self-payment gap accumulation. Subject to available savings.

*For Beat3, Beat3 Plus and Beat4, approved medicines for the following conditions are not subject to the non-CDL limit: organ transplant, chronic renal failure, multiple sclerosis, haemophilia, immunodeficiency. Medicine claims will be paid directly from Scheme risk.

**The default OTC choice is 1. R1 396 OTC limit. Members wishing to choose the self-payment gap accumulation option are welcome to contact Bestmed.

Preventative care benefits

Note: Benefits mentioned below shall be at 100% of Scheme tariff and may be subject to pre-authorisation, clinical protocols, preferred providers, designated service providers (DSPs), formularies, funding guidelines and the MediKredit Reference Price (MMAP).

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Respiratory syncytial virus (RSV) vaccines	One (1) single dose per lifetime for infants born between January and May. Indicated from birth up to six months of age.				
Flu vaccines	Applicable to all active members and beneficiaries. One (1) per beneficiary per annum.				
Pneumonia vaccines	The Scheme will identify high-risk individuals for immunisation. Children: As per schedule of Department of Health. Adults: Twice in a lifetime with booster above 65 years of age.				
Travel vaccines	Not applicable to benefit option.	Mandatory travel vaccines for typhoid, yellow fever, tetanus, meningitis, hepatitis and cholera from Scheme risk benefits. Quantity and frequency depending on product up to the maximum allowed amount.			
Paediatric immunisation	According to the Bestmed vaccine schedule.				
Baby growth and development assessments	Assessments are done at a Bestmed partner pharmacy clinic. Three (3) assessments per annum for beneficiaries 0-2 years.				
Oral / injectable / implantable female contraceptives OR intrauterine device (IUD)	Oral / injectable / implantable female contraceptives R2 176 per beneficiary per annum OR Intrauterine device (IUD) limited to R3 295 per beneficiary once every 5 years.	Oral / injectable / implantable female contraceptives R2 393 per beneficiary per annum OR Intrauterine device (IUD) limited to R3 595 per beneficiary once every 5 years.	Oral / injectable / implantable female contraceptives R2 610 per beneficiary per annum OR Intrauterine device (IUD) limited to R3 795 per beneficiary once every 5 years.		Oral / injectable / implantable female contraceptives R2 913 per beneficiary per annum OR Intrauterine device (IUD) limited to R4 225 per beneficiary once every 5 years.
Mammogram	Scheme tariff applies. Females 40 years and older. Once every 24 months.				
HPV vaccines	Three (3) vaccinations per beneficiary. Males and females 9 - 26 years.				
PSA screening	Can be done at a urologist or GP. Consultation paid from the available personal medical savings account (PMSA) / consultation benefit. Males 45 years and older. Once every 24 months.				
Pap smear	At any gynaecologist or GP. Beneficiaries 18 years and older. Once every 24 months.	At any gynaecologist or GP. Consultation fee paid from the available PMSA. Beneficiaries 18 years and older. Once every 24 months.			At any gynaecologist or GP. Consultation is paid at Scheme tariff from Scheme risk benefits. Beneficiaries 18 years and older. Once every 24 months.
Preventative dentistry	Not applicable to benefit option.	Subject to clinical protocols and funding guidelines. Refer to Preventative dentistry table below for a full breakdown of benefits per option.			
Colon cancer screening	The consultation shall be paid from the available consultation benefit. To be done at a GP or specialist. Faecal Occult Blood Test (FOBT). 40 years and older. Once every 24 months.				
HIV rapid test	Voluntary counselling and testing (VCT) subject to Scheme protocols and funding guidelines.				

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
PREVENTATIVE DENTISTRY					
General full-mouth examination by a general dentist (incl. gloves and use of sterile equipment)	Not applicable to benefit option.	Once per annum for members 12 years of age and above. Once every six months for members under 12 years.			
Full-mouth intra-oral radiographs	Not applicable to benefit option.	Once every 36 months for all ages.			
Intra-oral radiograph	Not applicable to benefit option.	Two (2) radiographs per annum for all ages.			
Scaling and/or polishing	Not applicable to benefit option.	Once every six months (i.e. every 6 months from the date of service) for all ages.			
Fluoride treatment	Not applicable to benefit option.	Once every six months (i.e. every 6 months from the date of service) for all ages.			
Fissure sealant	Not applicable to benefit option.	Up to and including 21 years of age.			
Space maintainers	Not applicable to benefit option.	Once per beneficiary per annum.			

Disclaimer on exclusions: General and option-specific exclusions apply. Please refer to www.bestmed.co.za for more details.

Maternity benefits

Note: Benefits mentioned below may be subject to registration, preferred providers, designated service providers (DSPs), formularies, funding guidelines and the MediKredit Reference Price (MMAP).

BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
100% Scheme tariff. Subject to the following benefits: **Consultations:** ▪ 6 antenatal consultations at a GP OR gynaecologist OR midwife. ▪ 2 post-natal consultations at a GP OR gynaecologist OR midwife. **Ultrasounds:** ▪ 1 x 2D ultrasound scan at 1st trimester (between 10 to 12 weeks) at a GP OR gynaecologist OR radiologist. ▪ 1 x 2D ultrasound scan at 2nd trimester (between 20 to 24 weeks) at a GP OR gynaecologist OR radiologist.	**100% Scheme tariff. Subject to the following benefits:** **Consultations:** ▪ 6 antenatal consultations at a GP OR gynaecologist OR midwife. ▪ 2 post-natal consultations at a GP OR gynaecologist OR midwife. **Ultrasounds:** ▪ 1 x 2D ultrasound scan at 1st trimester (between 10 to 12 weeks) at a GP OR gynaecologist OR radiologist. ▪ 1 x 2D ultrasound scan at 2nd trimester (between 20 to 24 weeks) at a GP OR gynaecologist OR radiologist. **Supplements:** ▪ Any item categorised as a maternity supplement can be claimed up to a maximum of R151 per claim, once a month, for a maximum of 9 months.	**100% Scheme tariff. Subject to the following benefits:** **Consultations:** ▪ 9 antenatal consultations at a GP OR gynaecologist OR midwife. ▪ 2 post-natal consultations at a GP OR gynaecologist OR midwife. **Ultrasounds:** ▪ 1 x 2D ultrasound scan at 1st trimester (between 10 to 12 weeks) at a GP OR gynaecologist OR radiologist. ▪ 1 x 2D ultrasound scan at 2nd trimester (between 20 to 24 weeks) at a GP OR gynaecologist OR radiologist. **Supplements:** ▪ Any item categorised as a maternity supplement can be claimed up to a maximum of R151 per claim, once a month, for a maximum of 9 months.		

In addition to the abovementioned benefits, the Maternity care programme offers:

- Choice of a maternity gift.
- Online pregnancy wellness class with rewards for mom-to-be.
- Access to a 24-hour medical advice line.
- Weekly emails with helpful tips about pregnancy, baby development and pregnancy symptoms.
- Emails sent (every two weeks) to partner / spouse / father to also inform them about the baby's development and mom's progress.
- Online childbirth classes with rewards for mom-to-be.
- Separate monitoring programme for high-risk patients.
- Trimester wellness calls.
- Post-birth support call.
- One online consultation with a Lactation Consultant.

(Subject to registration on the programme)
Access the Maternity care programme benefits guide: https://www.bestmed.co.za/benefits-and-cover/maternity-care#!benefits

ABBREVIATIONS

CDL = Chronic Disease List; DBC = Documentation Based Care (back rehabilitation programme); DSP = Designated Service Provider; GP = General Practitioner or Doctor; HPV = Human Papilloma Virus; M = Member; M1+ = Member and family; MMAP = MediKredit Reference Price; PMB = Prescribed Minimum Benefit; PMSA: personal medical savings account; PPN = Preferred Provider Negotiators; PSA = Prostate Specific Antigen; RSV = Respiratory syncytial virus.

Contributions

		BEAT1 N	BEAT1	BEAT2 N	BEAT2	BEAT3 N	BEAT 3	BEAT3 PLUS	BEAT4
Personal Medical Savings Account		**N/A**		**16%**		**15%**		**25%**	**14%**
Principal Member	Risk	R2 439	R2 712	R2 506	R2 785	R3 712	R4 125	R4 027	R6 872
	Savings	R0	R0	R477	R530	R655	R728	R1 343	R1 119
	Total	**R2 439**	**R2 712**	**R2 983**	**R3 315**	**R4 367**	**R4 853**	**R5 370**	**R7 991**
Adult Dependant	Risk	R1 896	R2 106	R1 947	R2 163	R2 648	R2 943	R2 992	R5 675
	Savings	R0	R0	R371	R412	R467	R519	R997	R924
	Total	**R1 896**	**R2 106**	**R2 318**	**R2 575**	**R3 115**	**R3 462**	**R3 989**	**R6 599**
Child Dependant	Risk	R999	R1 109	R1 025	R1 140	R1 311	R1 455	R1 491	R1 699
	Savings	R0	R0	R195	R217	R231	R257	R497	R277
	Total	**R999**	**R1 109**	**R1 220**	**R1 357**	**R1 542**	**R1 712**	**R1 988**	**R1 976**
		You pay for a maximum of three children. Any additional children join as beneficiaries on the Scheme at no additional cost.							
Recognition of a child dependant		Dependants under the age of 24 years are regarded as child dependants.							

PACE

The Pace range offers comprehensive in-hospital and out-of-hospital benefits. These options all have additional day-to-day benefits to cover extensive out-of-hospital expenses. This range is ideal for those seeking comprehensive cover.

Method of Scheme benefit payment

PACE1	PACE2	PACE3	PACE4
▪ In-hospital benefits are paid from Scheme risk benefit. Some out-of-hospital benefits are paid from the personal medical savings account (PMSA) first and once depleted will be paid from the day-to-day benefit. ▪ Once the day-to-day benefit is depleted, benefits can be paid from the available vested savings. Some preventative care benefits are available from Scheme risk benefit.			▪ In-hospital benefits, out-of-hospital benefits and preventative care benefits are paid from Scheme risk. ▪ Once out-of-hospital risk benefits are depleted, further claims will be paid from the personal medical savings account (PMSA).

In-hospital benefits

Benefits relating to conditions that meet the criteria for PMBs will be covered in full when using DSPs, and this will not affect your personal medical savings account (PMSA).

Note: All the below benefits are subject to pre-authorisation and clinical protocols.

All members must obtain pre-authorisation for planned procedures at least 14 (fourteen) days before the event. However, in the case of an emergency, you, your representative or the hospital must notify Bestmed of your hospitalisation as soon as possible or on the first working day after admission to hospital.

	PACE1	PACE2	PACE3	PACE4
Accommodation (hospital stay) in a general ward, intensive care and high-care unit, theatre and material	Benefits shall be at 100% Scheme tariff.			
To-take-out (TTO) / Take-home medicine	Benefits shall be at 100% Scheme tariff if claimed on the day of discharge, as follows: Up to 7 days treatment if claimed as part of the hospital account, or up to R700 if claimed from a retail pharmacy. Subject to MediKredit Reference Price (MMAP). No benefit if not claimed within 3 days from the date of discharge.			
Biological medicine during hospitalisation	Benefits shall be at 100% of Scheme tariff. Up to R37 887 per family per annum. Subject to pre-authorisation and funding guidelines.	Benefits shall be at 100% of Scheme tariff. Up to the Biological medicine benefit per beneficiary per annum as set out on page 33. Subject to pre-authorisation and funding guidelines.		
Treatment in mental health facilities	Benefits shall be at 100% Scheme tariff. Up to 21 days per beneficiary per annum in hospital, including inpatient electro-convulsive therapy and inpatient psychotherapy, OR 15 contact sessions for out-patient psychotherapy per beneficiary per annum. Subject to pre-authorisation and DSPs.			
Treatment of chemical and substance abuse Please refer to the Managed Care Guide	Benefits shall be limited to the treatment of PMB conditions and subject to the following: ▪ Pre-authorisation. ▪ DSPs. ▪ Up to 21 days' stay for in-hospital management per beneficiary per annum.			
Consultations and procedures	Benefits shall be at 100% Scheme tariff for claims submitted by General Practitioners (GPs) and specialists for treatment during hospitalisation.			
Surgical procedures and anaesthetics	Benefits shall be at 100% Scheme tariff.			
Supplementary services during hospitalisation	Benefits shall be at 100% Scheme tariff, 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, orthoptists, audiologists / hearing aid acousticians, occupational therapists, podiatrists / chiropodist, dietitians, speech therapists, biokineticists, stoma therapist and social workers.			
Organ transplants (in and/or out of hospital)	Benefits limited to PMBs only at DSPs.			

	PACE1	PACE2	PACE3	PACE4
Stem cell transplants	Benefits limited to PMBs only at DSPs.			
Blood transfusion	Benefits shall be at 100% Scheme tariff for blood, operators' fees, transport charges and apparatus.			
Pathology	Benefits shall be at 100% Scheme tariff.			
Basic radiology	Benefits shall be at 100% Scheme tariff.			
Specialised diagnostic imaging and nuclear medicine - in- and/ or out-of-hospital (including MRI scans, CT scans and nuclear / isotope studies). PET scans only included as indicated per benefit option	Benefits shall be at 100% Scheme tariff. Up to a combined in- and out-of-hospital benefit of R43 514 per family per annum. PET scans are limited to one (1) scan per beneficiary per annum. Subject to benefit confirmation and reference number received from the Scheme.	Benefits shall be at 100% Scheme tariff. Up to a combined in- and out-of-hospital benefit of R45 689 per family per annum. PET scans are limited to one (1) scan per beneficiary per annum. Subject to benefit confirmation and reference number received from the Scheme.		Benefits shall be at 100% Scheme tariff. Up to a combined in- and out-of-hospital benefit of R48 953 per family per annum. PET scans are limited to one (1) scan per beneficiary per annum. Subject to benefit confirmation and reference number received from the Scheme.
Dental and oral surgery (in and/or out of hospital subject to pre-authorisation)	**Benefits shall be at 100% Scheme tariff up to R10 626 per family per annum in or out of hospital:** ▪ Surgical extractions of teeth / roots / impactions / failed implants. ▪ Surgical drainage of dental abscess. ▪ Surgical removal of jaw cyst. ▪ Apicoectomy (root canal-related surgery). ▪ Orthognathic surgery. ▪ Bone augmentation (preparatory surgery for dental prosthesis). **Beneficiaries 7 years and younger, and beneficiaries with disabilities** The following procedures performed under sedation at a DSP day hospital and will be covered from the personal medical savings account (PMSA) at 100% Scheme tariff: ▪ Pulp procedures. ▪ Extractions. ▪ Restorations (fillings). **The following procedures will be covered from the personal medical savings account (PMSA) at 100% Scheme tariff:** ▪ Implant placements.	**Benefits shall be at 100% Scheme tariff up to R17 658 per family per annum in or out of hospital:** ▪ Surgical extractions of teeth / roots / impactions / failed implants. ▪ Surgical drainage of dental abscess. ▪ Surgical removal of jaw cyst. ▪ Apicoectomy (root canal-related surgery). ▪ Orthognathic surgery. ▪ Bone augmentation (preparatory surgery for dental prosthesis). **Beneficiaries 7 years and younger, and beneficiaries with disabilities** The following procedures performed under sedation at a DSP day hospital and will be covered from the personal medical savings account (PMSA) at 100% Scheme tariff: ▪ Pulp procedures. ▪ Extractions. ▪ Restorations (fillings). **The following procedures will be covered from the personal medical savings account (PMSA) at 100% Scheme tariff:** ▪ Implant placements.	**Benefits shall be at 100% Scheme tariff up to R22 188 per family per annum in or out of hospital:** ▪ Surgical extractions of teeth / roots / impactions / failed implants. ▪ Surgical drainage of dental abscess. ▪ Surgical removal of jaw cyst. ▪ Apicoectomy (root canal-related surgery). ▪ Orthognathic surgery. ▪ Bone augmentation (preparatory surgery for dental prosthesis). **Beneficiaries 7 years and younger, and beneficiaries with disabilities** The following procedures performed under sedation at a DSP day hospital and will be covered from the personal medical savings account (PMSA) at 100% Scheme tariff: ▪ Pulp procedures. ▪ Extractions. ▪ Restorations (fillings). **The following procedures will be covered from the personal medical savings account (PMSA) at 100% Scheme tariff:** ▪ Implant placements.	**Benefits shall be at 100% Scheme tariff up to R26 564 per family per annum in or out of hospital:** ▪ Surgical extractions of teeth / roots / impactions / failed implants. ▪ Surgical drainage of dental abscess. ▪ Surgical removal of jaw cyst. ▪ Apicoectomy (root canal-related surgery). ▪ Orthognathic surgery. ▪ Bone augmentation (preparatory surgery for dental prosthesis). **Beneficiaries 7 years and younger, and beneficiaries with disabilities** The following procedures performed under sedation at a DSP day hospital and will be covered from the personal medical savings account (PMSA) at 100% Scheme tariff: ▪ Pulp procedures. ▪ Extractions. ▪ Restorations (fillings). **The following procedures will be covered from the personal medical savings account (PMSA) at 100% Scheme tariff:** ▪ Implant placements.
Major maxillofacial surgery limited to surgical procedures that fall under the scope of maxillofacial surgeons (Subject to pre-authorisation)	Benefits shall be at 100% Scheme tariff. Up to R17 188 per family per annum, including TMJ procedures: ▪ Arthrocentesis. ▪ Arthroplasty.	Benefits shall be at 100% Scheme tariff, including TMJ procedures: ▪ Arthrocentesis. ▪ Arthroplasty. ▪ Reconstruction or replacement of temporomandibular joint.		

	PACE1	PACE2	PACE3	PACE4
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 **Note:** Sub-limits subject to availability of overall prosthesis limit Overall annual prosthesis limit (subject to preferred providers, otherwise limits and co-payments apply) *Functional: items used to replace or augment an impaired bodily function	Benefits shall be paid at 100% Scheme tariff up to R118 757 per family per annum. Sub-limits per beneficiary per annum: ▪ *Functional R40 622. ▪ Vascular R77 661. ▪ Pacemaker (single and dual chamber) R73 911. ▪ Spinal including artificial disc R43 283. ▪ Drug-eluting stents – subject to Vascular prosthesis limit. ▪ Mesh R16 251. ▪ Gynaecology / urology R11 720. ▪ Lens implants R8 908 a lens per eye. ▪ Endovascular and catheter-based procedures - subject to the Vascular prosthesis limit.	Benefits shall be paid at 100% Scheme tariff up to R152 508 per family per annum. Sub-limits per beneficiary per annum: ▪ *Functional R43 012. ▪ Vascular R77 661. ▪ Pacemaker (single and dual chamber) R82 425. ▪ Spinal including artificial disc R76 458. ▪ Drug-eluting stents R25 002. ▪ Mesh R25 002. ▪ Gynaecology / urology R18 672. ▪ Lens implants R16 033 a lens per eye. ▪ Joint replacements: - Hip replacement and other major joints R68 674. - Knee and shoulder replacements R79 692. - Other minor joints, including temporomandibular joint (TMJ) prosthesis R29 610. ▪ Endovascular and catheter-based procedures - subject to the Vascular prosthesis limit.	Benefits shall be paid at 100% Scheme tariff up to R153 290 per family per annum. Sub-limits per beneficiary per annum: ▪ *Functional R43 012. ▪ Vascular R82 440. ▪ Pacemaker (single and dual chamber) R82 425. ▪ Spinal including artificial disc R76 603. ▪ Drug-eluting stents R25 002. ▪ Mesh R25 002. ▪ Gynaecology / urology R18 751. ▪ Lens implants R16 033 a lens per eye. ▪ Joint replacements: - Hip replacement and other major joints R68 752. - Knee and shoulder replacements R80 081. - Other minor joints, including temporomandibular joint (TMJ) prosthesis R29 610. ▪ Endovascular and catheter-based procedures - subject to the Vascular prosthesis limit.	Benefits shall be paid at 100% Scheme tariff up to R176 884 per family per annum. Sub-limits per beneficiary per annum: ▪ *Functional R47 791. ▪ Vascular R82 440. ▪ Pacemaker (single and dual chamber) R82 425. ▪ Spinal including artificial disc R88 450. ▪ Drug-eluting stents R29 456. ▪ Mesh R25 940. ▪ Gynaecology / urology R21 407. ▪ Lens implants R23 704 a lens per eye. ▪ Joint replacements: - Hip replacement and other major joints R79 146 - Knee and shoulder replacements R91 645. - Other minor joints, including temporomandibular joint (TMJ) prosthesis R29 456. ▪ Endovascular and catheter-based procedures - subject to the Vascular prosthesis limit.
Exclusions on joint replacement surgery for non-PMB conditions. (Prosthesis sub-limits form part of overall Internal prosthesis limit subject to preferred provider, otherwise limits and co-payments apply)	Joint replacement surgery excluded (except for PMBs). PMBs subject to prosthesis limits: ▪ Hip replacement and other major joints R44 064. ▪ Knee and shoulder replacements R58 598. ▪ Other minor joints R18 205.	No exclusions applicable.		
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	Benefits shall be at 100% of Scheme tariff. Up to R30 158 per family per annum. Includes artificial limbs, up to one (1) limb every 60 months. Repair work to artificial limbs will be funded from the out-of-hospital Medical aids, apparatus and appliances benefit.	Benefits shall be at 100% of Scheme tariff. Up to R35 939 per family per annum. Includes artificial limbs, up to one (1) limb every 60 months. Repair work to artificial limbs will be funded from the out-of-hospital Medical aids, apparatus and appliances benefit.	Benefits shall be at 100% of Scheme tariff. Up to R36 096 per family per annum. Includes artificial limbs, up to one (1) limb every 60 months. Repair work to artificial limbs will be funded from the out-of-hospital Medical aids, apparatus and appliances benefit.	Benefits shall be at 100% of Scheme tariff. Up to R40 785 per family per annum. Includes artificial limbs, up to one (1) limb every 60 months. Repair work to artificial limbs will be funded from the out-of-hospital Medical aids, apparatus and appliances benefit.
Orthopaedic and medical appliances **Note:** Appliances directly relating to the hospital admission and/or procedure	Benefits shall be at 100% Scheme tariff up to R18 000 per family per annum for medically necessary appliances for back, leg, arm and neck support, crutches, surgical footwear and elastic stockings directly related to the admission and provided before discharge from hospital.	Benefits shall be at 100% Scheme tariff up to R19 000 per family per annum for medically necessary appliances for back, leg, arm and neck support, crutches, surgical footwear and elastic stockings directly related to the admission and provided before discharge from hospital.		Benefits shall be at 100% Scheme tariff up to R20 000 per family per annum for medically necessary appliances for back, leg, arm and neck support, crutches, surgical footwear and elastic stockings directly related to the admission and provided before discharge from hospital.

	PACE1	PACE2	PACE3	PACE4
Oncology (in and/or out of hospital) Please refer to the Managed Care Guide	Benefit shall be at 100% Scheme tariff, subject to pre-authorisation, designated or preferred service providers, and protocols. Essential ICON protocols apply.		Benefit shall be at 100% Scheme tariff, subject to pre-authorisation, designated or preferred service providers and protocols. Essential, Core and Enhanced level ICON protocols apply. Additional access to biological / high cost medicine cover limited to the biological / high cost medicine benefit.	
Breast surgery for cancer	Treatment of the **unaffected (non-cancerous) breast** will be limited to PMB provisions and is subject to pre-authorisation and funding guidelines.			
Medically necessary breast reduction surgery (including fees for all providers, hospital and procedure)	Not applicable to benefit option.		Benefit shall be at 100% Scheme tariff up to R100 000 per family per annum. Subject to funding protocols and pre-authorisation.	
Peritoneal dialysis and haemodialysis Please refer to the Managed Care Guide	Benefits shall be at 100% Scheme tariff. Subject to pre-authorisation and designated or preferred service providers.			
HIV/AIDS benefits (in and/or out of hospital) Please refer to the Managed Care Guide	Benefits shall be at 100% Scheme tariff. Subject to pre-authorisation and designated or preferred service providers, with LifeSense as the Managed care organisation.			
Confinements (birthing, including midwife-assisted births)	Benefits shall be at 100% Scheme tariff for: ▪ 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. ▪ 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.			
Refractive surgery and other procedures (in and/or out of hospital) done to improve or stabilise vision (except cataracts)	Benefits shall be at 100% Scheme tariff. Subject to pre-authorisation and protocols. Up to R11 813 per eye.	Benefits shall be at 100% Scheme tariff. Subject to pre-authorisation and protocols. Up to R12 344 per eye.	Benefits shall be at 100% Scheme tariff. Subject to pre-authorisation and protocols. Up to R13 283 per eye.	
Corneal cross-linking	Benefit shall be at 100% of Scheme tariff per beneficiary for clinically appropriate treatment of corneal conditions (e.g. keratoconus). Subject to pre-authorisation.			
Alternative to hospitalisation (i.e. procedures done in the doctor's rooms)	Benefits shall be at 100% Scheme tariff subject to pre-authorisation. Step-down facilities approved by the Scheme and services must be rendered by registered private nurses and hospices.			
Cochlear implants and bone-anchored hearing aid (BAHA) implants (including fees for all providers, hospital and device)	Benefits shall be at 100% Scheme tariff up to R250 000 per beneficiary per annum. Subject to pre-authorisation and Preferred Providers or DSPs. Sound processor upgrades every 5 years.	Benefits shall be at 100% Scheme tariff up to R285 000 per beneficiary per annum. Subject to pre-authorisation and Preferred Providers or DSPs. Sound processor upgrades every 5 years.	Benefits shall be at 100% Scheme tariff up to R320 000 per beneficiary per annum. Subject to pre-authorisation and Preferred Providers or DSPs. Sound processor upgrades every 5 years.	Benefits shall be at 100% Scheme tariff up to R350 000 per beneficiary per annum. Subject to pre-authorisation and Preferred Providers or DSPs.Sound processor upgrades every 5 years.
Varicose veins procedure in hospital	Benefit shall be at 100% Scheme tariff for the treatment of varicose veins performed in a hospital. Subject to pre-authorisation and day hospital rules and funding guidelines.			
Advanced illness benefit	Benefits shall be at 100% Scheme tariff, up to R94 716 per beneficiary per annum. Subject to available benefit, pre-authorisation and treatment plan.	Benefits shall be at 100% Scheme tariff, up to R151 545 per beneficiary per annum. Subject to available benefit, pre-authorisation and treatment plan.		
Day procedures at a day hospital facility	Day procedures performed in a day hospital by a DSP provider will be funded at 100% network or Scheme tariff subject to: pre-authorisation; protocols and funding guidelines; and DSPs and preferred providers. Please refer to Day Procedure List on page 53. A co-payment of R2 987 will 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 day procedure co-payment will not apply if done in acute hospital, if it is arranged with the Scheme before the time.			

	PACE1	PACE2	PACE3	PACE4
Ambulance and emergency evacuation services	Benefits shall be subject to provisions of benefits by Netcare 911, as the Scheme's capitated preferred provider for ambulance services. Benefits shall only be payable if the evacuation service was involuntarily requested and delivered by a service provider other than the preferred provider: Provided that services in respect of PMB conditions shall be payable at cost, without deductibles or the use of co-payments, subject to the provisions of Scheme Rules. Authorisation needs to be obtained directly from Netcare 911.			
International medical travel cover	▪ **Holiday travel:** Up to 90 days and R5 000 000 per family, i.e. members and dependants. Limited to R1 000 000 per family for travel to the USA. ▪ **Business travel:** Up to 60 days and R5 000 000 per family, i.e. members and dependants. Limited to R1 000 000 per family for travel to the USA.			

Out-of-hospital benefits

Note: Benefits below may be subject to pre-authorisation, clinical protocols, preferred providers, designated service providers (DSPs), formularies, funding guidelines and the MediKredit Reference Price (MMAP). Members are required to obtain pre-authorisation for all planned treatments and/or procedures, PMB services and chronic medication. Approved PMBs will be paid from Scheme risk.

	PACE1	PACE2	PACE3	PACE4
Overall day-to-day limit	The following combined overall limit for day-to-day benefits shall apply per annum: M = R14 346 and M1+ = R28 689.	The following combined overall limit for day-to-day benefits shall apply per annum: M = R17 922 and M1+ = R35 844.	The following combined overall limit for day-to-day benefits shall apply per annum: M = R23 949 and M1+ = R49 494.	The following combined overall limit for day-to-day benefits shall apply per annum: M = R47 190 and M1+ = R76 099.
GP, nurse and specialist consultations Including consultations, visits, diagnostic examinations, injections and emergency unit visits (where a procedure room was used) with GPs, contracted nursing clinical services, contracted primary care drug therapy (PCDT) pharmacists, specialists, homeopaths and herbalists	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA) first. Once the funds in the PMSA have been depleted, benefits shall be subject to the overall day-to-day limit and the following maximum limits per annum: M = R2 954 and M1+ = R5 938.	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA) first. Once the funds in the PMSA have been depleted, benefits shall be subject to the overall day-to-day limit and the following maximum limits per annum: M = R5 470 and M1+ = R11 087.	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA) first. Once the funds in the PMSA have been depleted, benefits shall be subject to the overall day-to-day limit and the following maximum limits per annum: M = R5 783 and M1+ = R11 720.	Benefits shall be at 100% Scheme tariff subject to the overall day-today limit and the following maximum limits per annum: M = R7 422 and M1+ = R12 033.
Emergency room consultations / casualty visits	Benefit shall be at 100% Scheme tariff up to two (2) emergency room (ER) or casualty ward visits per family per annum, subject to a limit of R3 000 per event. The limits include costs for doctor consultations, facility fees, radiology, pathology and medicine used during the treatment in the ER.			

	PACE1	PACE2	PACE3	PACE4
Dental benefit Including check-ups, fillings, extractions, root canals, crowns, bridges, dentures, periodontal treatment	Benefits shall be at 100% Scheme tariff from personal medical savings account (PMSA) first. Once the personal medical savings account (PMSA) is depleted, the following limits apply: M = R5 437 and M1+ = R11 033. ▪ Periodontics services (gum diseases). ▪ Orthodontic services (correction of malaligned teeth by means of braces, retainers or similar treatment) are subject to pre-authorisation. Covered once per beneficiary per lifetime. ▪ Dental implants, implant costs and all laboratory costs related to the aforementioned services.	Benefits shall be at 100% Scheme tariff from personal medical savings account (PMSA) first. Thereafter, the following limits apply: M = R9 112 and M1+ = R18 228. ▪ Periodontics services (gum diseases). ▪ Orthodontic services (correction of malaligned teeth by means of braces, retainers or similar treatment) are subject to pre-authorisation. Covered once per beneficiary per lifetime. ▪ Dental implants, implant costs and all laboratory costs related to the aforementioned services. **Orthodontic services up to 18 years:** Subject to pre-authorisation. Up to R8 840 for beneficiaries up to 18 years of age. (Subject to overall day-to-day limit.) Covered once per beneficiary per lifetime.	Benefits shall be at 100% Scheme tariff from personal medical savings account (PMSA) first. Thereafter, the following limits apply: M = R9 820 and M1+ = R18 307. ▪ Periodontics services (gum diseases). ▪ Orthodontic services (correction of malaligned teeth by means of braces, retainers or similar treatment) are subject to pre-authorisation. Covered once per beneficiary per lifetime. ▪ Dental implants, implant costs and all laboratory costs related to the aforementioned services. **Orthodontic services up to 18 years:** Subject to pre-authorisation. Up to R11 366 for beneficiaries up to 18 years of age. (Subject to overall day-to-day limit.) Covered once per beneficiary per lifetime.	Benefits shall be at 100% Scheme tariff subject to overall day-to-day limit and the following maximum limits per annum: M = R16 389 and M1+ = R27 662. ▪ Periodontics services (gum diseases). ▪ Orthodontic services (correction of malaligned teeth by means of braces, retainers or similar treatment) are subject to pre-authorisation. Covered once per beneficiary per lifetime. ▪ Dental implants, implant costs and all laboratory costs related to the aforementioned services. **Orthodontic services up to 18 years:** Subject to pre-authorisation. Up to R13 891 for beneficiaries up to 18 years of age. (Subject to overall day-to-day limit.) Covered once per beneficiary per lifetime.
General full-mouth examination by a general dentist (incl. gloves and use of sterile equipment)	Once per annum for members 12 years of age and above. Once every six months for members under 12 years (paid from preventative dentistry benefit as per Preventative dentistry table on page 35).			
Full-mouth intra-oral radiographs	Once every 36 months for all ages (paid from preventative dentistry benefit as per Preventative dentistry table on page 35).			
Intra-oral radiograph	Two (2) radiographs per annum for all ages (paid from preventative dentistry benefit as per Preventative dentistry table on page 35).			
Scaling and/or polishing	Once every six months (i.e. every 6 months from the date of service) for all ages (paid from preventative dentistry benefit as per Preventative dentistry table on page 35).			
Fluoride treatment	Once every six months (i.e. every 6 months from the date of service) for all ages (paid from preventative dentistry benefit as per Preventative dentistry table on page 35).			
Fissure sealant	Up to and including 21 years years of age (paid from preventative dentistry benefit as per Preventative dentistry table on page 35).			
Space maintainers	Once per beneficiary per annum (paid from preventative dentistry benefit as per Preventative dentistry table on page 35).			
Medical aids, apparatus and appliances	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA). Once the funds in the PMSA have been depleted, benefits shall be subject to the overall day-to-day limit and R15 158 per family per annum for appliances that shall include any of the items listed below: ▪ Back, leg, arm and neck support. ▪ Surgical footwear. ▪ Crutches. ▪ Elastic stockings. ▪ Repair work on artificial limbs, wheelchairs, etc. ▪ Stoma products. ▪ Oxygen and diabetic supplies for non-PMB conditions.	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA). Once the funds in the PMSA have been depleted, benefits shall be subject to the overall day-to-day limit and R13 750 per family per annum for appliances that shall include any of the items listed below: ▪ Back, leg, arm and neck support. ▪ Surgical footwear. ▪ Crutches. ▪ Elastic stockings. ▪ Repair work on artificial limbs, wheelchairs, etc. ▪ Stoma products. ▪ Oxygen and diabetic supplies for non-PMB conditions.		Benefits shall be at 100% Scheme tariff subject to the overall day-to-day limit and R13 750 per family per annum for appliances that shall include any of the items listed below: ▪ Back, leg, arm and neck support. ▪ Surgical footwear. ▪ Crutches. ▪ Elastic stockings. ▪ Repair work on artificial limbs, wheelchairs, etc. ▪ Stoma products. ▪ Oxygen and diabetic supplies for non-PMB conditions. ▪ Insulin pump consumables.

	PACE1	PACE2	PACE3	PACE4
Wheel chairs	Subject to medical apparatus and appliance limits.	Benefits shall be at 100% Scheme tariff, up to R18 595 per family every 48 (forty-eight) months.		
Hearing aids and repair work on hearing aids (Hearing aids subject to pre-authorisation)	Benefits shall be at 100% Scheme tariff. Up to R10 528 per family every 24 months. Subject to quotation, motivation and audiogram.	Benefits shall be at 100% Scheme tariff. Up to R34 811 per beneficiary every 24 months. Subject to quotation, motivation and audiogram.		Benefits shall be at 100% Scheme tariff. Up to R38 074 per beneficiary every 24 months. Subject to quotation, motivation and audiogram.
Insulin pump (excluding consumables)	Not applicable to benefit option.			Benefit shall be at 100% Scheme tariff. Up to R55 269 per beneficiary every 24 months. Subject to pre-authorisation.
Continuous / Flash Glucose Monitoring (CGM/FGM)	Refer to medical aids, apparatus and appliances limit listed above.		Benefit shall be at 100% Scheme tariff. Up to R25 257 per family per annum. Subject to pre-authorisation.	Benefit shall be at 100% Scheme tariff. Up to R31 571 per family per annum. Subject to pre-authorisation.
Supplementary services Benefits include services rendered by physiotherapists, orthoptists, audiologists / hearing aid acousticians, occupational therapists, podiatrists / chiropodist, dietitians, speech therapists, biokineticists, private nursing (stoma therapy nursing, obtaining of specimen, observations and administration of medication, immunisations and IV's), psychiatric treatment, psychologists and social workers	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA). Once the funds in the PMSA have been depleted, benefits shall be at 100% Scheme tariff subject to the overall day-to-day limit and the following maximum limit per annum: M = R5 797 and M1+ = R12 033.	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA). Once the funds in the PMSA have been depleted, benefits shall be at 100% Scheme tariff subject to the overall day-to-day limit and the following maximum limit per annum: M = R4 182 and M1+ = R8 364.	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA). Once the funds in the PMSA have been depleted, benefits shall be at 100% Scheme tariff subject to the overall day-to-day limit and the following maximum limit per annum: M = R3 532 and M1+ = R7 422.	Benefits shall be at 100% Scheme tariff subject to the overall day-to-day limit and the following maximum limit per annum: M = R7 422 and M1+ = R14 610.
Wound care benefit (including dressings, wound therapy, and related nursing services) Please refer to the Managed Care Guide	General wound care shall be at 100% Scheme tariff from the personal medical savings account (PMSA). Once the funds in the PMSA have been depleted, benefits shall be at 100% Scheme tariff subject to the overall day-to-day limit and R4 766 per family per annum.	General wound care shall be at 100% Scheme tariff from the personal medical savings account (PMSA). Once the funds in the PMSA have been depleted, benefits shall be at 100% Scheme tariff subject to the overall day-to-day limit and R8 575 per family per annum.	General wound care shall be at 100% Scheme tariff from the personal medical savings account (PMSA). Once the funds in the PMSA have been depleted, benefits shall be at 100% Scheme tariff subject to the overall day-to-day limit and R11 948 per family per annum.	General wound care shall be at 100% Scheme tariff subject to the overall day-to-day limit and R18 126 per family per annum.
Negative-pressure wound therapy (NPWT)	Benefit shall be at 100% Scheme tariff. Subject to pre-authorisation based on clinical motivation and an approved treatment plan.			
Varicose veins procedure in rooms Benefits include fees related to the procedure, all providers' fees, facility fees, material and catheters.	Benefits shall be at 100% Scheme tariff for the treatment of varicose veins performed in provider rooms. Subject to pre-authorisation and funding guidelines.			

	PACE1	PACE2	PACE3	PACE4
Optometry benefit	Benefits available every 24 months from date of service. **Network Provider (PPN)** Consultation - One (1) per beneficiary. Frame = R1 395 covered AND 100% of cost of standard lenses (single vision OR bifocal OR multifocal) OR Contact lenses = R2 190 OR **Non-network Provider** Consultation - R433 fee at non-network provider Frame = R1 046 AND Single vision lenses = R230 OR Bifocal lenses = R502 OR Multifocal lenses = R1 110 (consisting of R880 per base lens plus R230 per branded lens add-on) In lieu of glasses members can opt for contact lenses, limited to R2 190.	Benefits available every 24 months from date of service. **Network Provider (PPN)** Consultation - One (1) per beneficiary. Frame = R1 460 covered AND 100% of cost of standard lenses (single vision OR bifocal OR multifocal) AND Lens enhancement = R750 covered OR Contact lenses = R2 395 OR **Non-network Provider** Consultation - R433 fee at non-network provider Frame = R1 095 AND Single vision lenses = R230 OR Bifocal lenses = R502 OR Multifocal lenses = R1 110 (consisting of R880 per base lens plus R230 per branded lens add-on) AND Lens enhancements = R750 covered In lieu of glasses members can opt for contact lenses, limited to R2 395.		Benefits available every 24 months from date of service. **Network Provider (PPN)** Consultation - One (1) per beneficiary. Frame = R1 460 covered AND 100% of cost of standard lenses (single vision OR bifocal OR multifocal) AND Lens enhancement = R750 covered OR Contact lenses = R2 835 OR **Non-network Provider** Consultation - R433 fee at non-network provider Frame = R1 095 AND Single vision lenses = R230 OR Bifocal lenses = R502 OR Multifocal lenses = R1 110 (consisting of R880 per base lens plus R230 per branded lens add-on) Lens enhancement = R750 covered. In lieu of glasses members can opt for contact lenses, limited to R2 835.
Basic radiology and pathology	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA). Once the funds in the PMSA have been depleted, benefits shall be at 100% Scheme tariff subject to the overall day-to-day limit and the following maximum limit per annum: M = R4 297 and M1+ = R8 595.		Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA). Once the funds in the PMSA have been depleted, benefits shall be at 100% Scheme tariff subject to the overall day-to-day limit and the following maximum limit per annum: M = R4 688 and M1+ = R9 297.	Benefits shall be at 100% Scheme tariff subject to the overall day-to-day limit and the following maximum limit per annum: M = R7 422 and M1+ = R14 610.
Specialised diagnostic imaging and nuclear medicine - in and/or out of hospital (including MRI scans, CT scans and nuclear / isotope studies). PET scans only included as indicated per benefit option	Benefits shall be at 100% Scheme tariff. Up to a combined in- and out-of-hospital benefit of R43 514 per family per annum. PET scans are limited to one (1) scan per beneficiary per annum. Subject to benefit confirmation and reference number received from the Scheme.	Benefits shall be at 100% Scheme tariff. Up to a combined in- and out-of-hospital benefit of R45 689 per family per annum. PET scans are limited to one (1) scan per beneficiary per annum. Subject to benefit confirmation and reference number received from the Scheme.		Benefits shall be at 100% Scheme tariff. Up to a combined in- and out-of-hospital benefit of R48 953 per family per annum. PET scans are limited to one (1) scan per beneficiary per annum. Subject to benefit confirmation and reference number received from the Scheme.
Rehabilitation services after trauma	Benefits shall be at 100% Scheme tariff.			
Back and neck preventative programme Please refer to the Managed Care Guide	Benefits shall be payable at 100% of contracted fee and are applicable to all ages – subject to pre-authorisation: ▪ Applicable to beneficiaries with 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.			
HIV/AIDS benefits (in and/or out of hospital) Please refer to the Managed Care Guide	Benefits shall be at 100% Scheme tariff. Subject to pre-authorisation and designated or preferred service providers, with LifeSense as the Managed care organisation.			

	PACE1	PACE2	PACE3	PACE4
Oncology (in and/or out of hospital) Please refer to the Managed Care Guide	Benefits shall be at 100% Scheme tariff, subject to pre-authorisation, designated or preferred service providers and protocols. Essential ICON protocols apply.		Benefits shall be at 100% of Scheme tariff, subject to pre-authorisation, designated or preferred service providers and protocols. Essential, Core and Enhanced level ICON protocols apply. Additional access to biological / high cost medicine cover limited to the biological / high cost medicine benefit.	
Peritoneal dialysis and haemodialysis Please refer to the Managed Care Guide	Benefits shall be at 100% Scheme tariff. Subject to pre-authorisation and designated or preferred service providers.			

Medicine benefits

Benefits mentioned below may be subject to pre-authorisation, clinical protocols, preferred providers, designated service providers (DSPs), formularies, funding guidelines, the MediKredit Reference Price (MMAP) and the exclusions referred to in Annexure C of the registered Rules.

Note: Approved CDL, PMB and non-CDL chronic medicine costs will be paid from the non-CDL chronic medicine limit first. Thereafter, approved CDL and PMB chronic medicine costs will continue to be paid (unlimited) from Scheme risk. Members will not incur co-payments for approved PMB medications that are on the formulary for which there is no generic alternative.

Note: Approved PMB biological and non-PMB biological medicine costs will be paid from the biological limit first. Once the limit is depleted, only PMB biological medicine costs will continue to be paid unlimited from Scheme risk.

	PACE1	PACE2	PACE3	PACE4
Medicine for PMB conditions Including the conditions listed on the chronic disease list (CDL) Subject to pre-authorisation	Benefits shall be at 100% of Scheme tariff, subject to a co-payment of 25% for the voluntary use of non-formulary medicine.	Benefits shall be at 100% of Scheme tariff, subject to a co-payment of 20% for the voluntary use of non-formulary medicine.	Benefits shall be at 100% of Scheme tariff, subject to a co-payment of 15% for the voluntary use of non-formulary medicine.	Benefits shall be at 100% of Scheme tariff, subject to a co-payment of 10% for the voluntary use of non-formulary medicine.
Non-CDL chronic medicine Subject to pre-authorisation	8 conditions. Payment shall be limited to M = R8 751 and M1+ = R17 500 per annum. Medicine on the formulary shall be covered at 90% Scheme tariff with a 10% co-payment and non-formulary medicine shall be covered at 75% of Scheme tariff with a 25% co-payment.	20 conditions. Payment shall be limited to M = R11 948 and M1+ = R23 895 per annum. Medicine on the formulary shall be covered at 90% Scheme tariff with a 10% co-payment and non-formulary medicine shall be covered at 80% of Scheme tariff with a 20% co-payment.	20 conditions. Payment shall be limited to M = R18 360 and M1+ = R36 722 per annum. Medicine on the formulary shall be covered at 90% Scheme tariff with a 10% co-payment and non-formulary medicine shall be covered at 85% of Scheme tariff with a 15% co-payment.	29 conditions. Payment shall be limited to M = R26 172 and M1+ = R52 580 per annum. Medicine on the formulary shall be covered at 100% Scheme tariff and non-formulary medicine shall be covered at 90% of Scheme tariff with a 10% co-payment.
Biological medicine	Benefits limited to PMBs only as per funding protocol. Subject to pre-authorisation.	Benefits shall be paid at 100% Scheme tariff up to R218 616 per beneficiary per annum. Subject to pre-authorisation	Benefits shall be paid at 100% Scheme tariff up to R437 523 per beneficiary per annum. Subject to pre-authorisation.	Benefits shall be paid at 100% Scheme tariff up to R647 533 per beneficiary per annum. Subject to pre-authorisation.
Other high-cost medicine	Benefits shall be at 100% Scheme tariff. Subject to pre-authorisation.			

	PACE1	PACE2	PACE3	PACE4
Acute medicine	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA) for prescribed medicine, including registered homeopathic remedies, injections and herbal remedies with NAPPI codes. Once the funds in the PMSA have been depleted, benefits shall be at 100% Scheme tariff subject to the overall day-to-day limit and the following maximum limit per annum: M = R3 096 and M1+ = R6 407.	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA) for prescribed medicine, including registered homeopathic remedies, injections and herbal remedies with NAPPI codes. Once the funds in the PMSA have been depleted, benefits shall be at 100% Scheme tariff subject to the overall day-to-day limit and the following maximum limit per annum: M = R3 585 and M1+ = R7 169.	Benefits shall be at 100% Scheme tariff from the personal medical savings account (PMSA) for prescribed medicine, including registered homeopathic remedies, injections and herbal remedies with NAPPI codes. Once the funds in the PMSA have been depleted, benefits shall be at 100% Scheme tariff subject to the overall day-to-day limit and the following maximum limit per annum: M = R2 390 and M1+ = R5 376.	Benefits shall be at 90% Scheme tariff with a 10% co-payment for prescribed medicine, including registered homeopathic remedies, injections and herbal remedies with NAPPI codes. Subject to the overall day-to-day limit and the following maximum limit per annum: M = R11 161 and M1+ = R17 338.
Over-the-counter (OTC) medicine Includes sunscreen, vitamins and minerals with NAPPI codes on Scheme formulary	**Member choice: 1. R1 396 OTC limit per family OR 2. Access to full personal medical savings account (PMSA) for OTC purchases (after R1 396 limit) = self-payment gap accumulation. Subject to available personal medical savings account (PMSA).			Benefit shall be paid at 100% Scheme tariff from the personal medical savings account (PMSA).

*For all Pace options, approved medicines for the following conditions are not subject to the non-CDL limit: organ transplant, chronic renal failure, multiple sclerosis, haemophilia and immunodeficiency. Medicine claims will be paid directly from Scheme risk.
**The default OTC choice is 1. R1 396 OTC limit. Members wishing to choose the self-payment gap accumulation option are welcome to contact Bestmed.

Preventative care benefits

Note: Benefits mentioned below may be subject to pre-authorisation, clinical protocols, preferred providers, designated service providers (DSPs), formularies, funding guidelines and the MediKredit Reference Price (MMAP).

	PACE1	PACE2	PACE3	PACE4
Respiratory syncytial virus (RSV) vaccines	One (1) single dose per lifetime for infants born between January and May. Indicated from birth up to six months of age.			
Flu vaccines	Applicable to all active members and beneficiaries. One (1) per beneficiary per annum.			
Pneumonia vaccines	The Scheme will identify high-risk individuals for immunisation. Children: As per schedule of Department of Health. Adults: Twice in a lifetime with booster above 65 years of age.			
Travel vaccines	Mandatory travel vaccines for typhoid, yellow fever, tetanus, meningitis, hepatitis and cholera from Scheme risk benefits. Quantity and frequency depending on product up to the maximum allowed amount.			
Paediatric immunisation	According to the Bestmed vaccine schedule.			
Baby growth and development assessments	Assessments are done at a Bestmed partner pharmacy clinic. Three (3) assessments per annum for beneficiaries 0-2 years.			
Oral / injectable / implantable female contraceptives OR intrauterine device (IUD)	Oral / injectable / implantable female contraceptives R2 913 per beneficiary per annum OR Intrauterine device (IUD) limited to R4 225 per beneficiary once every 5 years.			
Glaucoma screening	Not applicable to benefit option.	Subject to service being received from the contracted Optometrist Network only. Beneficiaries 50 years and older. Once every 12 months.		

	PACE1	PACE2	PACE3	PACE4
Mammogram	Scheme tariff applies. Females 40 years and older. Once every 24 months.			
HPV vaccines	Three (3) vaccinations per beneficiary. Males and females 9 - 26 years.			
PSA screening	Can be done at a urologist or GP. Consultation paid from the available personal medical savings account (PMSA) / consultation benefit. Males 45 years and older. Once every 24 months.			
Bone densitometry	Beneficiaries 45 years and older. Once every 24 months.			
Pap smear	At a gynaecologist or GP. Consultation is paid at Scheme tariff from Scheme risk benefits. Beneficiaries 18 years and older. Once every 24 months.			
Preventative dentistry	Subject to clinical protocols and funding guidelines. Refer to the Preventative dentistry table below a full breakdown of benefits per option.			
Colon cancer screening	To be done at a GP or specialist, the consultation shall be paid from the available consultation benefit. Faecal Occult Blood Test (FOBT). 40 years and older. Once every 24 months.			
HIV rapid test	Voluntary counselling and testing (VCT) subject to Scheme protocols and funding guidelines.			
PREVENTATIVE DENTISTRY				
General full-mouth examination by a general dentist (incl. gloves and use of sterile equipment)	Once per annum for members 12 years of age. and above. Once every six months for members under 12 years.			
Full-mouth intra-oral radiographs	Once every 36 months for all ages.			
Intra-oral radiograph	Two (2) radiographs per annum for all ages.			
Scaling and/or polishing	Once every six months (i.e. every 6 months from the date of service) for all ages.			
Fluoride treatment	Once every six months (i.e. every 6 months from the date of service) for all ages.			
Fissure sealant	Up to and including 21 years years of age.			
Space maintainers	Once per beneficiary per annum.			

Disclaimer on exclusions: General and option-specific exclusions apply. Please refer to www.bestmed.co.za for more details.

Maternity benefits

Note: Benefits mentioned below may be subject to registration, preferred providers, designated service providers (DSPs), formularies, funding guidelines and the MediKredit Reference Price (MMAP).

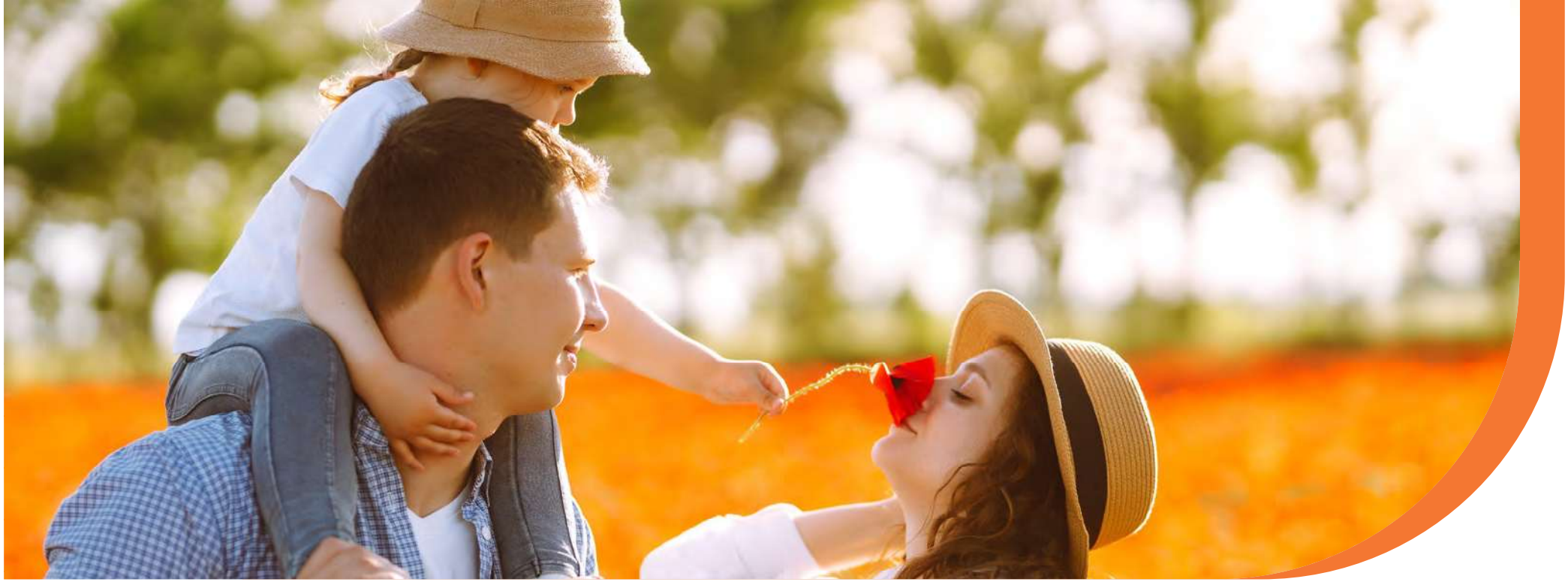
PACE1	PACE2	PACE3	PACE4
100% Scheme tariff. Subject to the following benefits: **Consultations:** ▪ 9 antenatal consultations at a GP OR gynaecologist OR midwife. ▪ 2 post-natal consultations at a GP OR gynaecologist OR midwife. **Ultrasounds:** ▪ 1 x 2D ultrasound scan at 1st trimester (between 10 to 12 weeks) at a GP OR gynaecologist OR radiologist. ▪ 1 x 2D ultrasound scan at 2nd trimester (between 20 to 24 weeks) at a GP OR gynaecologist OR radiologist. **Supplements:** ▪ Any item categorised as a maternity supplement can be claimed up to a maximum of R151 per claim, once a month, for a maximum of 9 months.			

In addition to the abovementioned benefits, the Maternity care programme offers:

- Choice of a maternity gift.
- Online pregnancy wellness class with rewards for mom-to-be.
- Access to a 24-hour medical advice line.
- Weekly emails with helpful tips about pregnancy, baby development and pregnancy symptoms.
- Emails sent (every two weeks) to partner / spouse / father to also inform them about the baby's development and mom's progress.
- Online childbirth classes with rewards for mom-to-be.
- Separate monitoring programme for high-risk patients.
- Trimester wellness calls.
- Post-birth support call.
- One online consultation with a Lactation Consultant.

(Subject to registration on the programme)
Access the Maternity care programme benefits guide: https://www.bestmed.co.za/benefits-and-cover/maternity-care#!benefits

ABBREVIATIONS
DBC = Documentation Based Care (Back Rehabilitation Programme); DSP = Designated Service Provider; GP = General Practitioner or Doctor; HPV = Human Papilloma Virus; M = Member; M1+ = Member and family; MRI/CT scans = Magnetic Resonance Imaging / Computed Tomography scans; MMAP = MediKredit Reference Price; NP = Network Provider; PET scan = Positron Emission Tomography scan; PMB = Prescribed Minimum Benefits; PMSA = personal medical savings account; PPN = Preferred Provider Negotiators; PSA = Prostate Specific Antigen; RSV = Respiratory syncytial virus.



Contributions

		PACE1	PACE2	PACE3	PACE4
Personal Medical Savings Account		**19%**	**14%**	**14%**	**3%**
Principal Member	Risk	R5 143	R8 179	R9 390	R13 232
	Savings	R1 206	R1 332	R1 529	R409
	Total	**R6 349**	**R9 511**	**R10 919**	**R13 641**
Adult Dependant	Risk	R3 717	R8 021	R7 559	R13 232
	Savings	R872	R1 306	R1 231	R409
	Total	**R4 589**	**R9 327**	**R8 790**	**R13 641**
Child Dependant	Risk	R1 336	R1 803	R1 615	R3 099
	Savings	R313	R294	R263	R96
	Total	**R1 649**	**R2 097**	**R1 878**	**R3 195**
You pay for a maximum of three children. Any additional children join as beneficiaries on the Scheme at no additional cost.					
Recognition of a child dependant		Dependants under the age of 24 years are regarded as child dependants.			

RHYTHM

RHYTHM IS IDEALLY SUITABLE FOR YOU IF:

- You are seeking a plan option that is based on your income.
- You are comfortable with making use of designated service providers (DSPs) within our Rhythm network.
- You are looking for unlimited comprehensive cover for hospitalisation and the added benefit of preventative care.

Method of Scheme benefit payment

RHYTHM1 AND RHYTHM2
▪ In-hospital benefits are paid from Scheme risk. ▪ Some preventative care benefits are available from Scheme risk. ▪ Some out-of-hospital benefits are paid from Scheme risk. ▪ Benefits relating to conditions that meet the criteria for PMBs will be covered in full when using DSPs.

In-hospital benefits

Note: All the below benefits are subject to pre-authorisation and clinical protocols.

All members must obtain pre-authorisation for planned procedures at least 14 (fourteen) days before the event. However, in the case of an emergency, you, your representative or the hospital must notify Bestmed of your hospitalisation as soon as possible or on the first working day after admission to hospital.

	RHYTHM1	RHYTHM2
Accommodation (hospital stay) in a general ward, intensive care and high-care unit, theatre and material Subject to pre-authorisation	Benefits limited to PMBs only at DSPs.	Benefits shall be at 100% Scheme tariff at a DSP hospital.
To-take-out (TTO) / Take-home medicine	Benefits shall be at 100% Scheme tariff if claimed on the day of discharge, as follows: Up to a maximum of 7 days treatment if claimed as part of the hospital account, or up to R468 if claimed from a retail pharmacy. Subject to MediKredit Reference Price (MMAP). No benefit if not claimed within 3 days from the date of discharge.	
Biological medicine during hospitalisation	Benefits limited to PMBs only at DSPs.	Benefits shall be at 100% Scheme tariff up to R18 944 per family per annum. Subject to pre-authorisation and funding guidelines.
Treatment in mental health facilities	Benefits limited to PMBs only at DSPs. Up to 21 days per beneficiary per annum in hospital including inpatient electro-convulsive therapy and inpatient psychotherapy, OR 15 contact sessions for out-patient psychotherapy per beneficiary per annum. Subject to pre-authorisation.	Benefits shall be at 100% Scheme tariff. Up to 21 days per beneficiary per annum, including inpatient electro-convulsive therapy and inpatient psychotherapy, OR 15 contact sessions for outpatient psychotherapy per beneficiary per annum. Subject to pre-authorisation and DSPs.
Treatment of chemical and substance abuse Please refer to the Managed Care Guide	Benefits shall be limited to the treatment of PMB conditions and subject to the following: ▪ Pre-authorisation. ▪ DSPs. ▪ Up to 21 days' stay for in-hospital management per beneficiary per annum.	
Consultations and procedures	Benefits limited to PMBs only at DSPs. Subject to pre-authorisation.	Benefits shall be at 100% Scheme tariff for claims submitted by General Practitioners (GPs) and specialists for treatment during hospitalisation. Subject to pre-authorisation and DSP network.
Surgical procedures and anaesthetics	Benefits limited to PMBs only at DSPs. Subject to pre-authorisation.	Benefits shall be at 100% Scheme tariff. Subject to pre-authorisation and DSP network.

	RHYTHM1	RHYTHM2
Supplementary services during hospitalisation	Benefits shall be at 100% Scheme tariff, 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, orthoptists, audiologists / hearing aid acousticians, occupational therapists, podiatrists / chiropodist, dietitians, speech therapists, biokineticists, stoma therapist and social workers.	
Organ transplants (in and/or out of hospital)	Benefits limited to PMBs only at DSPs.	
Stem cell transplants (in and/or out of hospital)	Benefits limited to PMBs only at DSPs.	
Blood transfusion	Benefits shall be at 100% Scheme tariff for blood, operators' fees, transport charges and apparatus.	
Pathology	Benefits limited to PMBs only at DSPs.	Benefits shall be at 100% Scheme tariff.
Basic radiology	Benefits limited to PMBs only at DSPs.	Benefits shall be at 100% Scheme tariff.
Specialised diagnostic imaging and nuclear medicine - in- and/ or out-of-hospital (including MRI scans, CT scans and nuclear / isotope studies) PET scans only included as indicated per benefit option	Benefits limited to PMBs only at DSPs. PET scans - Benefits limited to PMBs. Subject to benefit confirmation and reference number received from the Scheme.	Benefit shall be at 100% Scheme tariff. Up to a combined in- and out-of-hospital benefit of R19 581 per family per annum. PET scans - Benefits limited to PMBs. Subject to benefit confirmation and reference number received from the Scheme.
Dental and oral surgery (in and/or out of hospital subject to pre-authorisation)	Benefits limited to PMBs only at DSPs.	
Major maxillofacial surgery, strictly related to certain conditions (Subject to pre-authorisation)	Benefits limited to PMBs only at DSPs.	
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 **Note:** Sub-limits subject to availability of overall prosthesis limit. DSPs apply Overall annual prosthesis limit (subject to preferred providers and DSPs, otherwise limits and co-payments apply) *Functional: items used to replace or augment an impaired bodily function	Benefits shall be paid at 100% Scheme tariff up to R69 848 per family per annum. Sub-limits per beneficiary per annum: ▪ *Functional R37 038. ▪ Vascular R59 739. ▪ Pacemaker (single and dual chamber) R56 566. ▪ Spinal including artificial disc R34 609. ▪ Drug-eluting stents – subject to Vascular prosthesis limit. DSPs apply. ▪ Mesh R12 658. ▪ Gynaecology / urology R10 455. ▪ Lens implants R7 268 a lens per eye. ▪ Endovascular and catheter-based procedures - subject to Vascular prosthesis limit.	
Exclusions on joint replacement surgery for non-PMB conditions. (Prosthesis sub-limits form part of overall Internal prosthesis limit subject to preferred provider, otherwise limits and co-payments apply)	Joint replacement surgery excluded (except for PMBs). PMBs subject to prosthesis limits: ▪ Hip replacement and other major joints R35 471. ▪ Knee and shoulder replacements R44 847. ▪ Minor joints R16 797. Functional nasal surgery and surgical procedures where CNS stimulators are used (e.g. epilepsy, Parkinson disease, etc.) will be excluded from benefits, except for PMB conditions.	
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	Benefits limited to PMBs only at DSPs.	

	RHYTHM1	RHYTHM2
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 and where such a prescription directly relates to the admission and provided before discharge from hospital. ▪ Back, leg, arm and neck support. ▪ Crutches. ▪ Surgical footwear (excluding health footwear). ▪ Elastic stockings.	Benefits shall be at 100% Scheme tariff up to R8 595 per family per annum for medically necessary appliances or 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. ▪ Crutches. ▪ Surgical footwear (excluding health footwear). ▪ Elastic stockings. ▪ Oxygen, diabetic and stoma aids continually essential for the medical treatment of the patient. ▪ Medical apparatus continually essential for the medical treatment of the patient.
Oncology (in and/or out of hospital) Please refer to the Managed Care Guide	Oncology benefits funded at PMB level of care only, subject to pre-authorisation, designated or preferred service providers and protocols. Essential ICON protocols apply.	Benefits shall be at 100% Scheme tariff, subject to pre-authorisation, designated or preferred service providers and protocols. Essential ICON protocols apply.
Breast surgery for cancer	Treatment of the **unaffected (non-cancerous) breast** will be limited to PMB provisions and is subject to pre-authorisation and funding guidelines.	
Peritoneal dialysis and haemodialysis (in and/or out of hospital) Please refer to the Managed Care Guide	Benefits limited to PMBs only at DSPs.	Benefits shall be at 100% Scheme tariff. Subject to pre-authorisation, protocols and designated or preferred service providers.
Confinements (birthing, including midwife-assisted births)	Benefits limited to PMBs only at DSPs and emergency caesarean sections (C-sections) at DSPs.	Benefits shall be at 100% Scheme tariff for: ▪ 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. ▪ 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.
Refractive surgery and other procedures (in and/or out of hospital) done to improve or stabilise vision (except cataracts)	Benefits limited to PMBs only at DSPs.	
Corneal cross-linking	Benefit shall be at 100% of Scheme tariff per beneficiary for clinically appropriate treatment of corneal conditions (e.g. keratoconus). Subject to pre-authorisation.	
Cochlear implants and bone anchored hearing aids (BAHA) implants (Including fees for all providers, hospital and device	Benefits limited to PMBs only at DSPs.	
HIV/AIDS benefits (in and/or out of hospital) Please refer to the Managed Care Guide	Benefits limited to PMBs only at DSPs.	Benefits shall be at 100% Scheme tariff. Subject to pre-authorisation, protocols and designated or preferred service providers, with LifeSense as the Managed care organisation.

	RHYTHM1	RHYTHM2
Alternative to hospitalisation (i.e. procedures done in the doctor's rooms)	Benefits limited to PMBs only at DSPs.	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.
Advanced illness benefit	Benefits limited to PMBs only at DSPs. Subject to pre-authorisation and treatment plan.	Benefits shall be at 100%. Scheme tariff. Up to R75 772 per beneficiary per annum. Subject to available benefit, pre-authorisation and treatment plan.
Day procedures at a day hospital facility	**PMBs in network day hospitals:** Benefits limited to PMBs only at DSPs. Subject to pre-authorisation, protocols and funding guidelines. **Non-PMBs in network day-hospitals:** Benefits shall be at 100% Scheme tariff. Subject to approved DSPs and pre-authorisation. Up to R59 739 per family per annum for non-PMB day procedures. A R2 987 co-payment will 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 day procedure co-payment will not apply if done in acute hospital, if it is arranged with the Scheme before the time. The non-PMB conditions covered are: ▪ Circumcision. ▪ Colonoscopy. ▪ Gastroscopy. ▪ Myringotomy and grommet insertion. ▪ Sterilisation (male and female). ▪ Tonsillectomy and adenoidectomy.	Day procedures performed in a day hospital by a DSP provider will be funded at 100% network or Scheme tariff, subject to pre-authorisation, protocols, funding guidelines and DSPs. A R2 987 co-payment will 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 day procedure co-payment will not apply if done in acute hospital, if it is arranged with the Scheme before the time.
Co-payments	**Non-network hospital co-payment:** Co-payment of R15 626 per event for voluntary use of a non-DSP hospital.	
Ambulance and emergency evacuation services	Benefits shall be subject to provisions of benefits by Netcare 911, as the Scheme's capitated preferred provider for ambulance services. Benefits shall only be payable if the evacuation service was involuntarily requested and delivered by a service provider other than the preferred provider: Provided that services in respect of PMB conditions shall be payable at cost, without deductibles or the use of co-payments, subject to the provisions of Scheme Rules. Authorisation needs to be obtained directly from Netcare 911.	
International medical travel cover	▪ Holiday travel: Up to 90 days and R5 000 000 per family, i.e. members and dependants. Up to R1 000 000 per family for travel to the USA. ▪ Business travel: Up to 60 days and R5 000 000 per family, i.e. members and dependants. Up to R1 000 000 per family for travel to the USA.	

Out-of-hospital benefits

Note: Benefits under the primary care services and the Scheme benefits shall be subject to treatment protocols, preferred providers, designated service providers (DSPs), dental procedure codes, pathology and radiology lists of codes and medicine formularies, funding guidelines and the MediKredit Reference Price (MMAP) as accepted by the Scheme.

Members are required to obtain pre-authorisation for all planned treatments and/or procedures, PMB services and chronic medication.

	RHYTHM1	RHYTHM2
Overall day-to-day limit	Not applicable to benefit option.	
GP consultations including consultations, visits, diagnostic examinations and injections	Benefits shall be at 100% of Scheme tariff for consultations per family, visits and treatments by GPs registered on the Rhythm Network for the following: ▪ Unlimited medically necessary consultations for basic primary care. ▪ Pre-approval is required after the 10th (tenth) visit.	Benefits shall be at 100% of Scheme tariff for consultations per family, visits and treatments by GPs registered on the Rhythm Network for the following: ▪ Unlimited medically necessary consultations for basic primary care. ▪ Specified minor trauma treatment, including stitches, excision and repair, drainage of abscess and limb cast.
Pharmacy clinic nurse consultations	Benefits shall be at 100% Scheme tariff. Unlimited primary care nurse consultations (tariff code 6119).	Not applicable to benefit option.
Casualty and out-of-network GP visits	Benefits limited to PMBs only at DSPs.	Every family qualifies for out-of-network GP and casualty visits: Benefits shall be at 100% of Scheme tariff up to R1 874 per family per annum. 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. The Member shall pay for the visit first and then claim back from the Scheme.
Specialist consultations Including minor procedures done in specialist rooms and all consumable used according to treatment protocol and clinical funding guidelines	Specialist consultations must be referred by a Rhythm Network Provider. Benefits shall be at 100% Scheme tariff. Up to R2 777 per family per annum. Subject to Rhythm Specialist Network.	Specialist consultations must be referred by a Rhythm Network Provider. Benefits shall be at 100% Scheme tariff. Limited to M = R1 895 and M1+ = R3 158. Subject to Rhythm Specialist Network.
Dental benefit including check-ups, fillings, extractions and dentures (dentures only applicable to Rhythm2)	Benefits shall be at 100% Scheme tariff per annum when clinically appropriate, subject to a designated service provider, the Rhythm Dental Network approved tariff list and conditions, as well as the following provisions: ▪ 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. ▪ Dentures not applicable to benefit option. ▪ Primary extractions if clinically necessary.	Benefits shall be at 100% 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: ▪ 2 (two) consultations for full mouth examination per beneficiary per financial year, subject to the Scheme's list of dental codes. ▪ Extraction if clinically necessary. ▪ Preventative treatment once every 6 (six) months per beneficiary including scaling and polishing and fluoride treatment. ▪ Limited to a maximum of 1 (one) set of dentures (i.e. 2 (two) single denture plates) per family per 24 (twenty-four) months. Benefits shall be subject to the use of accredited dental laboratories.
Medical aids, apparatus and appliances	Benefits limited to PMBs only at DSPs.	
Wheelchairs	Benefits limited to PMBs only at DSPs.	
Hearing aids	Benefits limited to PMBs only at DSPs.	

	RHYTHM1	RHYTHM2
Supplementary services Benefits include services rendered by physiotherapists, orthoptists, audiologists / hearing aid acousticians, occupational therapists, podiatrists / chiropodist, dietitians, speech therapists, biokineticists, 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	Benefits limited to PMBs only at DSPs.	
Wound care benefit (including dressings, wound therapy, and related nursing services) Please refer to the Managed Care Guide	Benefits limited to PMBs only at DSPs.	
Negative-pressure wound therapy (NPWT)	Benefits limited to PMBs only at DSPs.	
Basic radiology and pathology (in and/or out of hospital)	Benefits shall be at 100% Scheme tariff. Referral by Bestmed Rhythm Network GP or Rhythm Specialist DSP. Subject to Bestmed Rhythm protocols and approved radiology and pathology codes.	
Specialised diagnostic imaging and nuclear medicine - in and/or out of hospital (including MRI scans, CT scans and nuclear / isotope studies) PET scans only included as indicated per benefit option	Benefits limited to PMBs only at DSPs. PET scans - Benefits limited to PMBs. Subject to benefit confirmation and reference number received from the Scheme.	Benefit shall be at 100% Scheme tariff. Up to a combined in- and out-of-hospital benefit of R19 581 per family per annum. PET scans - Benefits limited to PMBs. Subject to benefit confirmation and reference number received from the Scheme.
Rehabilitation services after trauma	Benefits limited to PMBs only at DSPs. Subject to pre-authorisation and DSPs.	
Back and neck preventative programme Please refer to the Managed Care Guide	Benefits shall be payable at 100% of contracted fee and are applicable to all ages – subject to pre-authorisation: ▪ Applicable to beneficiaries with 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.	
HIV/AIDS benefits (in and/or out of hospital) Please refer to the Managed Care Guide	Benefits limited to PMBs only at DSPs.	Benefits shall be at 100% of Scheme tariff. Subject to pre-authorisation, protocols and designated or preferred service providers, with LifeSense as the Managed care organisation.
Oncology (in and/or out of hospital) Please refer to the Managed Care Guide	Oncology benefits funded at PMB level of care only, subject to pre-authorisation, designated or preferred service providers and protocols. Essential ICON protocols apply.	Benefits shall be at 100% 100% Scheme tariff, subject to pre-authorisation, designated or preferred service providers and protocols. Essential ICON protocols apply.
Peritoneal dialysis and haemodialysis Please refer to the Managed Care Guide	Benefits limited to PMBs only at DSPs.	Benefits shall be at 100% of Scheme tariff. Subject to pre-authorisation, protocols and designated or preferred service providers.

	RHYTHM1	RHYTHM2
Optometry benefit	Benefits available every 24 months from date of service. **Network Provider (PPN)** One (1) consultation (eye test) at optometrist network per beneficiary per annum. No benefit for spectacle frames, lenses or contact lenses. OR **Non-network Provider** One (1) consultation per beneficiary = R433 No benefit for spectacle frames, lenses or contact lenses.	Benefits available every 24 months from date of service. **Network Provider (PPN)** Consultation - One (1) per beneficiary. Frame = R340 covered AND 100% of cost of standard lenses (single vision OR bifocal OR multifocal) OR Contact lenses = R835 OR **Non-network Provider** Consultation - R433 fee at non-network provider Frame = R255 AND Single vision lenses = R230 OR Bifocal lenses = R502 OR Multifocal lenses = R502. In lieu of glasses members can opt for contact lenses, limited to R835.

Medicine benefits

Benefits mentioned below may be subject to pre-authorisation, clinical protocols, preferred providers, designated service providers (DSPs), formularies, funding guidelines, the MediKredit Reference Price (MMAP) and the exclusions referred to in Annexure C of the registered Rules.

Members will not incur co-payments for approved PMB medications that are on the formulary for which there is no generic alternative.

	RHYTHM1	RHYTHM2
Medicine for PMB conditions including the conditions listed on the chronic disease list (CDL) Subject to pre-authorisation	Benefits shall be at 100% Scheme tariff. A co-payment of 30% applies to non-formulary medicine.	
Non-CDL chronic medicine	Not applicable to benefit option.	
Biological medicine	Benefits limited to PMBs only at DSPs, as per funding protocol. Subject to pre-authorisation.	
Other high-cost medicine	Benefits limited to PMBs only at DSPs, as per funding protocol. Subject to pre-authorisation.	
Acute medicine	Benefits shall be at 100% of Scheme tariff for: ▪ Medicine on the formulary prescribed by a Rhythm Network provider and obtained at a preferred pharmacy network provider. ▪ Certain formulary medicines may be subject to annual quantity limits. ▪ Benefit not applicable to non-formulary acute medicine.	
Over-the-counter (OTC) medicine Includes sunscreen, vitamins and minerals with NAPPI codes on Scheme formulary	Benefits shall be at 100% Scheme tariff. Up to R261 per family per annum and up to R125 per event. Subject to preferred pharmacy network provider.	Benefits shall be at 100% Scheme tariff. Up to R381 per family per annum and up to R122 per event. Subject to preferred pharmacy network provider.

Preventative care benefits

Note: Benefits mentioned below may be subject to pre-authorisation, clinical protocols, preferred providers, designated service providers (DSPs), Rhythm network, formularies, funding guidelines and the MediKredit Reference Price (MMAP).

	RHYTHM1	RHYTHM2
Respiratory syncytial virus (RSV) vaccines	One (1) single dose per lifetime for infants born between January and May. Indicated from birth up to six months of age.	
Flu vaccines	Applicable to all active members and beneficiaries. One (1) per beneficiary per annum.	
Pneumonia vaccines	The Scheme will identify high-risk individuals for immunisation. Children: As per schedule of Department of Health. Adults: Twice in a lifetime with booster above 65 years of age.	
Travel vaccines	Mandatory travel vaccines for typhoid, yellow fever, tetanus, meningitis, hepatitis and cholera from Scheme risk benefits. Quantity and frequency depending on product up to the maximum allowed amount.	
Paediatric immunisation	According to the Bestmed vaccine schedule.	
Baby growth and development assessments	Assessments are done at a Bestmed partner pharmacy clinic. Three (3) assessments per annum for beneficiaries 0-2 years.	
Oral / injectable / implantable female contraceptives OR intrauterine device (IUD)	Oral / injectable / implantable female contraceptives R2 176 per beneficiary per annum OR Intrauterine device (IUD) limited to R3 295 per beneficiary once every 5 years.	Oral / injectable / implantable female contraceptives R2 393 per beneficiary per annum OR intrauterine device (IUD) up to the maximum of R3 295 per female beneficiary every 5 years.
Mammogram	Scheme tariff applies (tariff code 34100). Females 40 years and older. Once every 24 months. Must be referred by a Bestmed Rhythm Network GP or Rhythm Specialist DSP.	
HPV vaccines	Not applicable to benefit option.	Three (3) vaccinations per beneficiary. Males and females 9 - 26 years.
PSA screening	To be done at a DSP urologist or Rhythm Network GP. Urologist or GP consultation paid from the available consultation benefit. Males 45 years and older. Once every 24 months.	
Pap smear	At a Bestmed Rhythm Network GP or Rhythm Specialist DSP gynaecologist. Beneficiaries 18 years and older. Once every 24 months.	
Colon cancer screening	To be done at a Rhythm Network GP or DSP specialist, the consultation shall be paid from the available consultation benefit. Faecal Occult Blood Test (FOBT). 40 years and older. Once every 24 months.	
HIV rapid test	Voluntary counselling and testing (VCT) subject to Scheme protocols and funding guidelines.	

Disclaimer on exclusions: General and option specific exclusions apply. Please refer to www.bestmed.co.za for more details.

Maternity benefits

Note: Benefits mentioned below may be subject to registration, preferred providers, designated service providers (DSPs), formularies, funding guidelines and the MediKredit Reference Price (MMAP).

RHYTHM1	RHYTHM2
100% Scheme tariff at DSP network. Subject to the following benefits: **Consultations:** ▪ 6 antenatal consultations at a GP OR gynaecologist OR midwife. **Ultrasounds:** ▪ 1 x 2D ultrasound scan at 1st trimester (between 10 to 12 weeks) at a GP OR gynaecologist OR radiologist. ▪ 1 x 2D ultrasound scan at 2nd trimester (between 20 to 24 weeks) at a GP OR gynaecologist OR radiologist.	**100% Scheme tariff at DSP network. Subject to the following benefits:** **Consultations:** ▪ 9 antenatal consultations at either a GP OR gynaecologist OR midwife. ▪ 2 post-natal consultations at either a GP OR gynaecologist OR midwife. **Ultrasounds:** ▪ 1 x 2D ultrasound scan at 1st trimester (between 10 to 12 weeks) at a GP OR gynaecologist OR radiologist. ▪ 1 x 2D ultrasound scan at 2nd trimester (between 20 to 24 weeks) at a GP OR gynaecologist OR radiologist. **Supplements:** ▪ Any item categorised as a maternity supplement can be claimed up to a maximum of R151 per claim, once a month, for a maximum of 9 months.

In addition to the abovementioned benefits, the Maternity care programme offers:

- Choice of a maternity gift.
- Online pregnancy wellness class with rewards for mom-to-be.
- Access to a 24-hour medical advice line.
- Weekly emails with helpful tips about pregnancy, baby development and pregnancy symptoms.
- Emails sent (every two weeks) to partner / spouse / father to also inform them about the baby's development and mom's progress.
- Online childbirth classes with rewards for mom-to-be.
- Separate monitoring programme for high-risk patients.
- Trimester wellness calls.
- Post-birth support call.
- One online consultation with a Lactation Consultant.

(Subject to registration on the programme)
Access the Maternity care programme benefits guide: https://www.bestmed.co.za/benefits-and-cover/maternity-care#!benefits

ABBREVIATIONS
DBC = Documentation Based Care (Back Rehabilitation Programme); DSP = Designated Service Provider; GP = General Practitioner or Doctor; M = Member; M1+ = Member and family; MRI/CT scans = Magnetic Resonance Imaging / Computed Tomography scans; MMAP = MediKredit Reference Price; NP = Network Provider; PET scan = Positron Emission Tomography scan; PMB = Prescribed Minimum Benefits; PSA = Prostate Specific Antigen; PPN = Preferred Provider Negotiators; RSV = Respiratory syncytial virus.

Contributions

		RHYTHM1					RHYTHM2	
Income level		R0 – R9 000 pm	R9 001 – R14 000 pm	> R14 001 pm	Income level		R0 - R5 500pm	> R5 501 pm
Personal Medical Savings Account			**N/A**		**Personal Medical Savings Account**			**N/A**
Principal Member	Risk	R1 866	R2 176	R3 886	**Principal Member**	Risk	R3 214	R3 762
	Savings	R0	R0	R0		Savings	R0	R0
	Total	**R1 866**	**R2 176**	**R3 886**		**Total**	**R3 214**	**R3 762**
Adult Dependant	Risk	R1 866	R2 176	R3 886	**Adult Dependant**	Risk	R3 054	R3 387
	Savings	R0	R0	R0		Savings	R0	R0
	Total	**R1 866**	**R2 176**	**R3 886**		**Total**	**R3 054**	**R3 387**
Child Dependant	Risk	R769	R925	R2 013	**Child Dependant**	Risk	R1 882	R1 882
	Savings	R0	R0	R0		Savings	R0	R0
	Total	**R769**	**R925**	**R2 013**		**Total**	**R1 882**	**R1 882**
Maximum contribution child dependant		N/A	N/A	N/A	Maximum contribution child dependant		You pay for a maximum of three children. Any additional children join as beneficiaries on the Scheme at no additional cost.	
Recognition of a child dependant		Dependants under the age of 24 years are regarded as child dependants.			Recognition of a child dependant		Dependants under the age of 24 years are regarded as child dependants.	

Co-payments and conditions lists

When do co-payments apply for medicine claims?

- If medicine is prescribed / selected for the treatment of a CDL, PMB or non–CDL condition and is not listed on the formulary.
- If the prescribed / selected medicine costs more than the MediKredit Reference Price (MMAP).
- A formulary co-payment on non-CDL conditions is applicable depending on the chosen plan option.
- When the provider charges a higher dispensing fee than what the Scheme reimburses.

Please note that according to the Council for Medical Schemes (CMS) co-payments may not be deducted from your personal medical savings account (PMSA) account or vested savings account or reimbursed to you. The co–payment percentage varies according to the different benefit options. The table below highlights the different co–payments applicable per Scheme option for the CDL, PMB and non–CDL conditions:

Benefit	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4	PACE1	PACE2	PACE3	PACE4	RHYTHM 1 & 2
Non-formulary co-payment for CDL and PMB conditions	30%	30%	30%	30%	20%	25%	20%	15%	10%	30%
Formulary co-payment for non-CDL conditions	No benefit	No benefit	20%	20%	10%	10%	10%	10%	0%	No benefit
Non-formulary co-payment for non-CDL conditions	No benefit	No benefit	30%	30%	20%	25%	20%	15%	10%	No benefit

Chronic Conditions List

The Chronic Disease List (CDL) provides cover for the 27 listed chronic conditions for which medical schemes must cover the diagnosis, medical management and medicines as published by the Council for Medical Schemes. An additional 17 conditions are covered as Prescribed Minimum Benefits (PMB), where the medical management and medicines are also covered from Scheme benefits. Non-CDL chronic conditions are those additional conditions that Bestmed provides chronic medicine cover for. Authorisation for CDL, PMB and non-CDL chronic medicines is subject to clinical funding guidelines and protocols, formularies and Designated Service Providers (DSPs) where applicable. Approved CDL and PMB chronic medicines are covered without an annual financial limit while non-CDL chronic medicines are subject to an annual financial limit. Below is the list of CDL, PMB and non-CDL conditions that Bestmed covers on the various benefit options.

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4	PACE1	PACE2	PACE3	PACE4	RHYTHM 1 & 2
Number of non-CDL conditions	0	0	5	6	9	8	20	20	29	0
Reimbursement for CDL & PMB	100% of Scheme tariff									
Reimbursement for non-CDL	N/A	N/A	80%	80%	90%	90%	90%	90%	100%	N/A
Non-formulary co-payment for CDL and PMB conditions	30%	30%	30%	30%	20%	25%	20%	15%	10%	30%
Formulary co-payment for non-CDL conditions	N/A	N/A	20%	20%	10%	10%	10%	10%	0%	N/A
Non-formulary co-payment for non-CDL conditions	N/A	N/A	30%	30%	20%	25%	20%	15%	10%	N/A

		BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4	PACE1	PACE2	PACE3	PACE4	RHYTHM 1 & 2
CDL											
CDL 1	Addison disease	√	√	√	√	√	√	√	√	√	√
CDL 2	Asthma	√	√	√	√	√	√	√	√	√	√
CDL 3	Bipolar disorder	√	√	√	√	√	√	√	√	√	√
CDL 4	Bronchiectasis	√	√	√	√	√	√	√	√	√	√
CDL 5	Cardiac failure	√	√	√	√	√	√	√	√	√	√
CDL 6	Cardiomyopathy	√	√	√	√	√	√	√	√	√	√
CDL 7	Chronic obstructive pulmonary disease (COPD)	√	√	√	√	√	√	√	√	√	√
CDL 8	Chronic renal disease	√	√	√	√	√	√	√	√	√	√
CDL 9	Coronary artery disease	√	√	√	√	√	√	√	√	√	√
CDL 10	Crohn disease	√	√	√	√	√	√	√	√	√	√
CDL 11	Diabetes insipidus	√	√	√	√	√	√	√	√	√	√
CDL 12	Diabetes mellitus type 1	√	√	√	√	√	√	√	√	√	√
CDL 13	Diabetes mellitus type 2	√	√	√	√	√	√	√	√	√	√
CDL 14	Dysrhythmias	√	√	√	√	√	√	√	√	√	√
CDL 15	Epilepsy	√	√	√	√	√	√	√	√	√	√
CDL 16	Glaucoma	√	√	√	√	√	√	√	√	√	√
CDL 17	Haemophilia	√	√	√	√	√	√	√	√	√	√
CDL 18	HIV/AIDS	√	√	√	√	√	√	√	√	√	√
CDL 19	Hyperlipidaemia	√	√	√	√	√	√	√	√	√	√
CDL 20	Hypertension	√	√	√	√	√	√	√	√	√	√
CDL 21	Hypothyroidism	√	√	√	√	√	√	√	√	√	√
CDL 22	Multiple sclerosis	√	√	√	√	√	√	√	√	√	√
CDL 23	Parkinson disease	√	√	√	√	√	√	√	√	√	√
CDL 24	Rheumatoid arthritis	√	√	√	√	√	√	√	√	√	√
CDL 25	Schizophrenia	√	√	√	√	√	√	√	√	√	√
CDL 26	Systemic lupus erythematosus (SLE)	√	√	√	√	√	√	√	√	√	√
CDL 27	Ulcerative colitis	√	√	√	√	√	√	√	√	√	√

		BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4	PACE1	PACE2	PACE3	PACE4	RHYTHM 1 & 2
NON-CDL											
non-CDL 1	Acne - severe			√	√	√	√	√	√	√	
non-CDL 2	Allergic rhinitis			√	√	√	√	√	√	√	
non-CDL 3	Alzheimer disease							√	√	√	
non-CDL 4	Ankylosing spondylitis							√	√	√	
non-CDL 5	Attention deficit disorder / Attention deficit hyperactivity disorder (ADD/ ADHD)			√	√	√	√	√	√	√	
non-CDL 6	Autism							√	√	√	
non-CDL 7	Blepharospasm									√	
non-CDL 8	Collagen diseases							√	√	√	
non-CDL 9	Dermatomyositis							√	√	√	
non-CDL 10	Dystonia									√	
non-CDL 11	Eczema			√	√	√	√	√	√	√	
non-CDL 12	Gastro-oesophageal reflux disease (GORD)					√	√	√	√	√	
non-CDL 13	Gout prophylaxis					√	√	√	√	√	
non-CDL 14	Hypopituitarism									√	
non-CDL 15	Major depression*				√	√	√	√	√	√	
non-CDL 16	Migraine prophylaxis			√	√	√	√	√	√	√	
non-CDL 17	Motor neuron disease									√	
non-CDL 18	Neuropathy							√	√	√	
non-CDL 19	Obsessive-compulsive disorder					√		√	√	√	
non-CDL 20	Osteoarthritis							√	√	√	
non-CDL 21	Osteoporosis							√	√	√	
non-CDL 22	Paget disease of the bone							√	√	√	
non-CDL 23	Polyarteritis nodosa									√	

* Approved medicine claims will continue to be paid from Scheme risk once the non-CDL limit is depleted.

		BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4	PACE1	PACE2	PACE3	PACE4	RHYTHM 1 & 2
non-CDL 24	Psoriatic arthritis									√	
non-CDL 25	Psoriasis							√	√	√	
non-CDL 26	Scleroderma									√	
non-CDL 27	Sjögren's disease									√	
non-CDL 28	Trigeminal neuralgia									√	
non-CDL 29	Urinary incontinence							√	√	√	
PMB											
PMB 1	Aplastic anaemia	√	√	√	√	√	√	√	√	√	√
PMB 2	Benign prostatic hyperplasia	√	√	√	√	√	√	√	√	√	√
PMB 3	Cerebral palsy	√	√	√	√	√	√	√	√	√	√
PMB 4	Chronic anaemia	√	√	√	√	√	√	√	√	√	√
PMB 5	COVID-19	√	√	√	√	√	√	√	√	√	√
PMB 6	Cushing disease	√	√	√	√	√	√	√	√	√	√
PMB 7	Endometriosis	√	√	√	√	√	√	√	√	√	√
PMB 8	Female menopause	√	√	√	√	√	√	√	√	√	√
PMB 9	Fibrosing alveolitis	√	√	√	√	√	√	√	√	√	√
PMB 10	Graves disease	√	√	√	√	√	√	√	√	√	√
PMB 11	Hyperthyroidism	√	√	√	√	√	√	√	√	√	√
PMB 12	Hypophyseal adenoma	√	√	√	√	√	√	√	√	√	√
PMB 13	Idiopathic thrombocytopenic purpura	√	√	√	√	√	√	√	√	√	√
PMB 14	Paraplegia / quadriplegia	√	√	√	√	√	√	√	√	√	√
PMB 15	Polyendocrin metabolic ovarian syndrome	√	√	√	√	√	√	√	√	√	√
PMB 16	Pulmonary embolism	√	√	√	√	√	√	√	√	√	√
PMB 17	Stroke	√	√	√	√	√	√	√	√	√	√

Day procedure list

What type of specialist is your doctor?

Find your doctor's speciality and related procedures below. This list is designed to help guide you and may not include every procedure that falls within a particular speciality.

SPECIALIST	PROCEDURE
ENT surgeon	▪ Laryngeal endoscopy ▪ Middle ear and eardrum procedures (grommet insertion, mastoidectomy and myringoplasty) ▪ Nasal endoscopy ▪ Nasal procedures (septum and turbinate repairs) ▪ Nosebleed (epistaxis) treatment ▪ Sinus endoscopy ▪ Sinus washout (lavage) ▪ Tonsillectomy and adenoidectomy
General surgeon	▪ Abscess and cyst drainage ▪ Bile and pancreatic duct procedures (ERCP) ▪ Biopsies (bone, muscle, skin and soft tissue) ▪ Breast procedures (biopsies and lump removal) ▪ Bronchoscopy ▪ Digestive system endoscopy (gastroscopy and colonoscopy) ▪ Foreign body removal ▪ Hernia repairs ▪ Skin lesion removal ▪ Wound repairs
Gynaecologist	▪ Bartholin's cyst removal ▪ Cervical cerclage insertion or removal ▪ Colposcopy and cervical treatment procedures (including LLETZ) ▪ Endometrial ablation ▪ Hysteroscopic procedures (diagnostic hysteroscopy, dilation and curettage (D&C), and myomectomy) ▪ Laparoscopic procedures (diagnostic laparoscopy, ovarian cyst removal and sterilisation) ▪ Uterine evacuation

SPECIALIST	PROCEDURE
Orthopaedic surgeon	▪ Arthrodesis (joint fusion of the hand, foot or wrist) ▪ Arthroscopy (hip, knee, shoulder, ankle, elbow or wrist) ▪ Carpal tunnel release ▪ Closed fracture and dislocation treatment ▪ Fascia and muscle debridement ▪ Ganglion removal (ganglionectomy) ▪ Implant removal ▪ Nerve procedures (including neuroplasty and digital nerve excision) ▪ Tendon and ligament repair
Ophthalmologist	▪ Astigmatism correction ▪ Blepharoplasty (eyelid surgery) ▪ Cataract surgery ▪ Corneal transplant ▪ Eye laceration repair ▪ Foreign body removal from the eye ▪ Strabismus (squint) surgery ▪ Vitrectomy
Urologist	▪ Circumcision ▪ Cystoscopic procedures (biopsy, fulguration, stent insertion or removal and urethrotomy) ▪ Epididymis removal (epididymectomy) ▪ Hydrocele and varicocele procedures ▪ Orchidopexy (testicular fixation)

Preventative care benefits

BENEFIT	QUANTITY AND FREQUENCY	BENEFIT CRITERIA	BEAT	PACE	RHYTHM
Respiratory syncytial virus (RSV) vaccines	One (1) single dose per lifetime.	Infants born between January and May. Indicated from birth up to six months of age.	√	√	√
Flu vaccines	One (1) per beneficiary per annum.	Applicable to all active members and beneficiaries.	√	√	√
Pneumonia vaccines	Children: As per schedule of Department of Health. Adults: Twice in a lifetime with booster above 65 years of age.	The Scheme will identify high-risk individuals for immunisation.	√	√	√
Travel vaccines	Quantity and frequency depending on product up to the maximum allowed amount.	Mandatory travel vaccines for typhoid, yellow fever, tetanus, meningitis, hepatitis and cholera from Scheme risk benefits.	*Available on Beat2, Beat3, Beat3 Plus and Beat4	√	√
Paediatric immunisation	According to the Bestmed vaccine schedule.		√	√	√
Baby growth and development assessments	Three (3) assessments per annum for beneficiaries 0-2 years.	Assessments are done at a Bestmed partner pharmacy clinic.	√	√	√
Oral / injectable / implantable female contraceptives OR Intrauterine device (IUD)	Female contraceptive quantity and frequency dependent on product and subject to maximum amount OR 1 IUD device every 5 years.	Limits per female beneficiary per annum apply per benefit option for oral / injectable / implantable female contraceptives. IUD funding subject to applicable benefit limits per option.	√	√	√
Glaucoma screening	Beneficiaries 50 years and older. Once every 12 months.	Subject to service being received from the contracted Optometrist Network only.	X	*Available on Pace2, Pace3 and Pace4	X
Mammogram	Females 40 years and older. Once every 24 months.	Scheme tariff applies.	√	√	√
HPV vaccinations	Three (3) vaccinations per beneficiary. Males and females 9 - 26 years.		√	√	*Available on Rhythm2
PSA screening	Males 45 years and older. Once every 24 months.	Can be done at a urologist or GP. Consultation paid from the available personal medical savings account (PMSA) / consultation benefit.	√	√	√
Bone densitometry	Beneficiaries 45 years and older. Once every 24 months.		X	√	X
Pap smear	Beneficiaries 18 years and older. Once every 24 months.	At any gynaecologist or GP. Consultation is paid at Scheme tariff from Scheme risk benefits.	√ *Consultation cost available on Beat4	√ *Consultation cost available	√

BENEFIT	QUANTITY AND FREQUENCY	BENEFIT CRITERIA	BEAT	PACE	RHYTHM
Preventative dentistry	Refer to Comparative guide for a full breakdown of benefits per option.	Subject to clinical protocols and funding guidelines.	*Available on Beat2, Beat3, Beat3 Plus and Beat4	√	X
Colon cancer screening	40 years and older. Once every 24 months.	Faecal Occult Blood Test (FOBT).	√	√	√
HIV rapid test	Voluntary counselling and testing (VCT) subject to Scheme protocols and funding guidelines.		√	√	√

Preventative dentistry benefits

DESCRIPTION OF SERVICE	AGE	FREQUENCY	BEAT	PACE	RHYTHM
General full-mouth examination by a general dentist (incl. gloves and use of sterile equipment for the visit)	12 years and above	Once per annum	*Available on Beat2, Beat3, Beat3 Plus and Beat4	√	***Note:*** The Rhythm range offers preventative services under the dental benefit.
	Under 12 years of age	Once every six months	*Available on Beat2, Beat3, Beat3 Plus and Beat4	√	
Full-mouth intra-oral radiographs	All ages	Once every 36 months	*Available on Beat2, Beat3, Beat3 Plus and Beat4	√	
Intra-oral radiographs	All ages	2 photos per annum	*Available on Beat2, Beat3, Beat3 Plus and Beat4	√	
Scaling and/or polishing	All ages	Once every six months (i.e. every 6 months from the date of service)	*Available on Beat2, Beat3, Beat3 Plus and Beat4	√	
Fluoride treatment	All ages	Once every six months (i.e. every 6 months from the date of service)	*Available on Beat2, Beat3, Beat3 Plus and Beat4	√	
Fissure sealant	Up to and including 21 years of age		*Available on Beat2, Beat3, Beat3 Plus and Beat4	√	
Space maintainers	All ages	Once per beneficiary per annum.	*Available on Beat2, Beat3, Beat3 Plus and Beat4	√	

Bestmed exclusions

BEAT	GENERAL EXCLUSIONS	PROCEDURE EXCLUSIONS	
Beat1 Beat1 N	▪ Admissions for tests and investigations. ▪ Nutritional supplements, tonics, stimulants, vitamins and minerals. ▪ Surrogate pregnancy and delivery.	▪ Artificial insemination and infertility related procedures. ▪ Bariatric surgery and related weight loss medications. ▪ Bone-anchored hearing device implantation and upgrade. ▪ Breast reduction surgery. ▪ Cochlear device implantation and upgrade. ▪ Cosmetic procedures. ▪ Dental procedures: - Basic dentistry under sedation (IV or GA) i.e. extractions and restorations. - Bleaching of teeth. - Dentures. - Myobrace system. - Orthodontics. - Root canal treatment and other advanced dentistry. - Wisdom teeth extraction.	▪ External prosthesis. ▪ Gynaecomastia-related surgery. ▪ Non-PMB, deteriorated joint replacements: - Ankle. - Elbow. - Finger and toe. - Hip. - Knee. - Shoulder. - Temporomandibular joint (TMJ). ▪ Non-PMB refractive surgery. ▪ Robotic surgery. ▪ Varicose veins.
Beat2 Beat2 N	▪ Admissions for tests and investigations. ▪ Nutritional supplements, tonics, stimulants, vitamins and minerals if OTC limit is depleted. ▪ Surrogate pregnancy and delivery.	▪ Artificial insemination and infertility-related procedures. ▪ Bariatric surgery and related weight loss medications. ▪ Bone-anchored hearing device implantation and upgrade. ▪ Breast reduction surgery. ▪ Cochlear device implantation and upgrade. ▪ Cosmetic procedures. ▪ Dental procedures: - Bleaching of teeth. - Myobrace system. - Wisdom teeth extraction. ▪ External prosthesis. ▪ Gynaecomastia-related surgery	▪ Non-PMB, deteriorated joint replacements: - Ankle. - Elbow. - Finger and toe. - Hip. - Knee. - Shoulder. - Temporomandibular joint (TMJ). ▪ Non-PMB refractive surgery. ▪ Robotic surgery. ▪ Varicose veins.
Beat3 Beat3 N Beat3 Plus	▪ Admissions for tests and investigations. ▪ Nutritional supplements, tonics, stimulants, vitamins and minerals if OTC limit is depleted. ▪ Surrogate pregnancy and delivery.	▪ Artificial insemination and infertility-related procedures. ▪ Bariatric surgery and related weight loss medications. ▪ Bone anchored hearing aid implantation and upgrade. ▪ Breast reduction surgery. ▪ Cochlear device implantation and upgrade. ▪ Cosmetic procedures. ▪ Dental procedures: - Bleaching of teeth. - Myobrace system. ▪ External prosthesis.	▪ Gynaecomastia-related surgery. ▪ Non-PMB, deteriorated joint replacements: - Ankle. - Elbow. - Finger and toe. - Hip. - Knee. - Shoulder. - Temporomandibular joint (TMJ). ▪ Robotic surgery.
Beat4	▪ Admissions for tests and investigations. ▪ Nutritional supplements, tonics, stimulants, vitamins and minerals if OTC limit is depleted. ▪ Surrogate pregnancy and delivery.	▪ Artificial insemination and infertility-related procedures. ▪ Bariatric surgery and related weight loss medications. ▪ Breast reduction surgery. ▪ Cosmetic procedures. ▪ Dental procedures: - Bleaching of teeth. - Myobrace system. ▪ Gynaecomastia-related surgery.	▪ Non-PMB, deteriorated joint replacements: - Ankle. - Elbow. - Finger and toe. - Hip. - Knee. - Shoulder. - Temporomandibular joint (TMJ). ▪ Robotic surgery.

PACE	GENERAL EXCLUSIONS	PROCEDURE EXCLUSIONS	
Pace1	▪ Admissions for tests and investigations. ▪ Nutritional supplements, tonics, stimulants, vitamins and minerals if OTC limit is depleted. ▪ Surrogate pregnancy and delivery.	▪ Artificial insemination and infertility-related procedures. ▪ Bariatric surgery and related weight loss medications. ▪ Breast reduction surgery. ▪ Cosmetic procedures. ▪ Dental procedures: - Bleaching of teeth. - Myobrace system. ▪ Gynaecomastia-related surgery.	▪ Non-PMB, deteriorated joint replacements: - Ankle. - Elbow. - Finger and toe. - Hip. - Knee. - Shoulder. - Temporomandibular joint (TMJ). ▪ Robotic surgery.
Pace2	▪ Admissions for tests and investigations. ▪ Nutritional supplements, tonics, stimulants, vitamins and minerals if OTC limit is depleted. ▪ Surrogate pregnancy and delivery.	▪ Artificial insemination and infertility-related procedures. ▪ Bariatric surgery and related weight loss medications. ▪ Breast reduction surgery. ▪ Cosmetic procedures.	▪ Dental procedures: - Bleaching of teeth. - Myobrace system. ▪ Gynaecomastia-related surgery. ▪ Robotic surgery.
Pace3	▪ Admissions for tests and investigations. ▪ Nutritional supplements, tonics, stimulants, vitamins and minerals if OTC limit is depleted. ▪ Surrogate pregnancy and delivery.	▪ Artificial insemination and infertility-related procedures. ▪ Bariatric surgery and related weight loss medications. ▪ Cosmetic procedures. ▪ Dental procedures: - Bleaching of teeth. - Myobrace system.	▪ Gynaecomastia-related surgery. ▪ Robotic surgery.
Pace4	▪ Admissions for tests and investigations. ▪ Nutritional supplements, tonics, stimulants, vitamins and minerals if OTC limit is depleted. ▪ Surrogate pregnancy and delivery.	▪ Artificial insemination and infertility-related procedures ▪ Bariatric surgery and related weight loss medications. ▪ Cosmetic procedures.	▪ Dental procedures: - Bleaching of teeth. - Myobrace system. ▪ Gynaecomastia-related surgery. ▪ Robotic surgery.

RHYTHM1

Rhythm1 disclaimer: This list is intended as a guide and is not exhaustive. The items listed relate primarily to non-PMB conditions and are included to provide guidance on matters that may require further consideration or engagement. The inclusion or omission of any condition or item does not constitute a guarantee of funding, approval, or entitlement to benefits. Each request will be considered in accordance with the applicable benefit rules, clinical information and individual circumstances. Members are encouraged to engage with the Scheme where additional information or individual consideration may be relevant.

GENERAL EXCLUSIONS		MEDICAL ADMISSIONS FOR NON-PMB CONDITIONS	
▪ Admissions for tests and investigations. ▪ Nutritional supplements, tonics, stimulants, vitamins and minerals. ▪ Specialised radiology requests for non-PMB conditions.	▪ Standard radiology and pathology tests for non-PMB conditions. ▪ Surrogate pregnancy and delivery.	▪ Abdominal pain. ▪ Bronchitis / bronchiolitis. ▪ Cellulitis. ▪ Chickenpox. ▪ Conservative back and neck. ▪ Constipation.	▪ Dermatitis (skin rash). ▪ Gastro-oesophageal reflux. ▪ Headache. ▪ Non-infective gastroenteritis. ▪ Uncomplicated gastritis. ▪ Urinary tract infection.

RHYTHM1 PROCEDURE EXCLUSIONS FOR NON-PMB CONDITIONS

SPECIALIST CATEGORY	PROCEDURE		
Cardiothoracic surgeon	▪ Loop recorder implantation.		
Dermatologist	▪ Benign lesion excision.	▪ Hypertrophic scar and keloid excision.	
General surgeon	▪ Anogenital warts removal.	▪ ERCP.	▪ Ingrown toenail removal.
Gynaecologist	▪ Endometrial ablation. ▪ Hysteroscopy.	▪ Insertion of intra-uterine device. ▪ Uterine artery emboliation.	
Neurosurgeon	▪ CNS stimulator surgery: - Epilepsy. - Parkinson.	▪ Lumbar puncture. ▪ Scoliosis surgery. ▪ Spinal infiltrations and rhizotomy.	
Ophthalmologist	▪ Blepharoplasty. ▪ Keratectomy.	▪ Pterygium excision. ▪ Ptosis repair.	▪ Non-PMB refractive surgery. ▪ Strabismus.
Dental Specialist	▪ Dental treatments under sedation (IV or GA): - Examination. - Extractions. - Prophylaxis. - Restorations.	▪ Wisdom teeth extraction.	
Orthopaedic surgeon	▪ Arthroscopy: - Ankle. - Elbow. - Hip. - Knee. - Shoulder. - Wrist. ▪ Bunionectomy.	▪ Carpal tunnel repair. ▪ De Quervain repair. ▪ Joint aspiration and infiltration. ▪ Non-PMB, deteriorated joint replacements: - Ankle. - Elbow. - Finger and toe. - Hip.	- Knee. - Shoulder. ▪ Temporomandibular joint (TMJ). ▪ Plantar fasciitis surgery. ▪ Tennis elbow repair. ▪ Trigger finger repair.
Otorhinolaryngologist (ENT)	▪ Bone-anchored hearing aid implantation and upgrade. ▪ Cochlear device implantation and upgrade. ▪ Epistaxis.	▪ Functional nasal surgery: - FESS. - Septoplasty.	
Plastic and reconstruction surgeon	▪ Breast reduction surgery.	▪ Cosmetic surgery.	▪ Gynaecomastia-related surgery.
Urologist	▪ Management of urinary incontinence e.g. artificial urinary sphincter procedure.		▪ Robotic surgery.
Vascular surgeon	▪ Varicose veins.		

RHYTHM2			
GENERAL EXCLUSIONS	**PROCEDURE EXCLUSIONS**		
▪ Admissions for tests and investigations. ▪ Nutritional supplements, tonics, stimulants, vitamins and minerals if OTC limit is depleted. ▪ Surrogate pregnancy and delivery.	▪ Artificial insemination and infertility-related procedures. ▪ Bariatric surgery and related weight loss medications. ▪ Bone anchored hearing aid implantation and upgrade. ▪ Breast reduction surgery. ▪ Cochlear device implantation and upgrade. ▪ Cosmetic procedures.	▪ Dental procedures: - Basic dentistry under sedation (IV or GA) i.e. extractions and restorations. - Bleaching of teeth. - Myobrace system. - Orthodontics. - Root canal treatment and other advanced dentistry. - Surgical extractions. ▪ External prosthesis. ▪ Gynaecomastia-related surgery.	▪ Non-PMB, deteriorated joint replacements: - Ankle. - Elbow. - Finger and toe. - Hip. - Knee. - Shoulder. - Temporomandibular joint (TMJ). ▪ Non-PMB refractive surgery. ▪ Robotic surgery. ▪ Varicose veins.

Bestmed glossary of terms

TERMINOLOGY	DEFINITION
Alcohol and substance abuse care	Bestmed has contracted with various Designated Service Providers (DSPs) to provide rehabilitation for alcohol and substance abuse. Please note that this benefit is subject to pre-authorisation and will be funded up to a maximum limit or a duration of 21 days whichever is depleted first.
Azoza International travel cover	Bestmed members between the ages of 3 months and 86 years have access to R3 million in international travel cover through Azoza for all destinations excluding the USA. Destinations within the USA have a limit of R500 000 per family. This policy provides cover for up to a maximum of 45 (forty-five) days in the USA and 90 (ninety) days worldwide per trip, irrespective of how many flights are made during the year. It is essential that members familiarise themselves with the policy wording to ensure that they are familiar with all the terms and conditions of the policy.
Back and neck preventative care programme	The back and neck preventative programme's goal is to assist members with chronic back and/or neck pain and to improve the clinical state of the back and/or neck to prevent surgery. Documented Based Care (DBC) and Workability facilities are Bestmed's contracted healthcare providers for this programme.
Beat range	The Beat range offers flexible hospital benefits on all Beat options with a limited personal medical savings account (PMSA) to pay for out-of-hospital expenses on some options such as Beat2 and Beat-3, but extensive out-of-hospital cover on Beat4.
Biological and other high-cost medicine	Biological and other high-cost medicines are derived from a living source, for example interferon treatment for advanced melanoma.
Chronic Disease List (CDL)	The Chronic Disease List (CDL) provides cover for the 27 listed chronic conditions for which medical schemes must cover the diagnosis, medical management and medicines as published by the Council for Medical Schemes.
Clicks Direct, Dis-Chem Direct & Medipost Courier	These pharmacies are the preferred providers for rendering HIV/AIDS related services and post-exposure prophylaxis in the case of sexual assault.

TERMINOLOGY	DEFINITION
Confinement	Concluding the state of pregnancy, from contractions to birth of the child.
Contracted tariff / Contracted payment	The contracted tariff is the tariff as approved by the Board of Trustees and contractually agreed with service providers.
Co-payment	This is an amount that you need to pay towards a healthcare service which is not covered by the Scheme. The amount can vary by the type of covered healthcare service, place of service or if the amount the service provider charges is higher than the rate the Scheme pays.
CT scan	Computed tomography. A type of diagnostic imaging, using rotating x-rays and computers to create cross-sectional images of the soft tissues inside your body, bones and blood vessels.
Day-to-day benefit	Day-to-day refers to the amounts available for the payment of medical expenses incurred outside the hospital environment.
DSPs (designated service providers)	Specific groups of providers with the Scheme to render specified services at an agreed rate. They are healthcare providers that are considered the preferred choice for members' healthcare needs specifically related to PMB conditions.
Dialysis care	Members who require chronic dialysis for end-stage renal disease can register on the dialysis programme. Depending on clinical and other parameters, the Scheme will consider funding for peritoneal or haemodialysis. Certain medicines, which are used in end-stage renal disease, are only covered when the Scheme funding guidelines are met. Bestmed has appointed National Renal Care (NRC) as designated service provider (DSP) for renal dialysis services for its members on all the benefit options.
Discipline cover	If a specific hospital in the DSP hospital network cannot render a specific service, a hospital that can render the service in a 50km radius will be a preferred provider.

TERMINOLOGY	DEFINITION
Efficient discounted option (EDO)	This is a network option for which a member can apply for a decreased premium. The member sacrifices freedom of choice, should they apply for this option. This means that the member can make use of certain hospitals and specialists. A member will receive fewer savings if they choose this option. A member can only make use of Life Health Care, NHN, Medi-Clinic Hospitals, as well as specialists that are contracted to these hospitals. Day-to-day benefits remain the same applies on the Beat3 option. An EDO option is applicable on the Beat1, Beat2 and Beat3 options.
Endoscopic investigation	Endoscopy is an invasive diagnostic medical procedure that is used to assess the interior surface of an organ by inserting a tube with a camera in the body. Examples: gastroscopy, colonoscopy, cystoscopy.
Exclusions and PMBs	Medical schemes are entitled to exclude specific services/events e.g., cosmetic surgery, travel costs and examinations for insurance purposes etc.
Formulary	A formulary is a pre-determined list of medicines that will be covered for the CDL, non-CDL and PMB conditions. These lists of covered medicines vary from option to option. Bestmed makes use of formularies for each condition. These formularies are compiled and maintained by a team of professionals on the basis of evidence-based medicine, considering cost effectiveness and affordability. Bestmed allows flexibility in terms of every member and dependant's choice of medicine. If a member chooses to make use of a product that is not on the formulary, a co-payment will be applicable. This co-payment varies between the different benefit options, and forms part of Bestmed's Scheme Rules.
GP (General practitioner)	This is your and your family's doctor.
Functional prosthesis	Items utilised towards treating or supporting a bodily function.
General hospital	A hospital that does not specialise in the treatment of a particular service. A hospital that can render the service in a 50km radius will be a preferred provider.
General waiting periods and exclusions	If a member has a general three-month waiting period, the member is entitled to apply for CDL and PMB chronic benefits. If a member has a 12-month condition specific exclusion, the member cannot apply or claim for any services relating to that condition for a period of 12 months. The member also cannot apply for or claim for CDL and/ or PMB benefits if it relates to the specific condition.
Geographic cover	The locations or geographic area related to a case where there is no hospital that belongs to the specific DSP group hospital. Another hospital will be listed as the preferred hospital.
Gross monthly income	Means the applicant's gross monthly income before any deductions. Only applicants whose monthly income is less than the highest income category must provide proof of income. Applies to Rhythm benefit options.
ICD-10 Code	An ICD-10 code is a diagnosis code, indicating the illness or condition for which treatment is being received and is, therefore, compulsory on all medicine applications and prescriptions.
ICON (Independent Clinical Oncology Network)	ICON Managed Care is a provider-driven oncology managed care organisation that represents a significant number of the private practising oncologists in South Africa. The ICON Network comprises of radiotherapy facilities and accredited chemotherapy facilities across South Africa.

TERMINOLOGY	DEFINITION
Lens enhancements	Ophthalmic lens enhancements are additional lens technologies that can be added to a standard ophthalmic lens to improve the functionality and/or durability of the lens. Examples are tints, hard coating and anti-flex coating.
LifeSense	Bestmed has appointed LifeSense managed care to host our HIV/AIDS disease management programme. LifeSense has an excellent track record for managing and providing comprehensive management programmes for HIV/AIDS. They have ensured that members on the LifeSense programme remain clinically healthy, lead a productive life and stay active in their community.
Limit	The limit is the maximum benefit amount, which is paid for a specific service, apparatus, or appliance.
M	Member (single)
M +	Member and beneficiaries/dependants
Major medical benefits	Major medical benefits include hospitalisation, PMB and trauma recovery. Co-payments and sub-limits may be applicable in some cases.
Mammogram	A mammogram is the process of examining a human breast and is used as a diagnostic and a screening tool.
Maternity care	Pregnant members and dependants have access to the Maternity care programme. The programme provides comprehensive information and services and was designed with the needs of expectant parents and their support network in mind.
MediKredit Reference Price (MMAP)	The MediKredit Reference Price (MMAP) is a reference pricing model applicable to all medicines with generic equivalents or biosimilars. MMAP sets the maximum reimbursable price for a list of generically similar or biosimilar products with a cost lower than that of the original medicine. This means that if you opt to use a medicine that is more expensive than the MMAP, you will have to pay the difference between the price of the chosen medicine and that of MMAP.
MRI scan	Magnetic resonance imaging. A type of diagnostic imaging, using a large magnet and computer-generated radio waves to create detailed, cross-sectional images of your internal organs and tissues.
National Renal Care	Members requiring chronic dialysis for renal failure can register on the Dialysis programme. Depending on clinical and other parameters, the Scheme will consider funding for peritoneal or haemodialysis. Certain medicines that are used in end-stage renal failure are only covered when the Scheme funding guidelines are met. Bestmed has appointed National Renal Care (NRC) as designated service provider (DSP) for renal dialysis services for members on all the benefit options.
Network benefit option	Network options offer benefits to members in collaboration with a medical provider network. In the case of the Rhythm and Beat EDO benefit options, day-to-day services are rendered by a network of general providers registered and contracted with Bestmed.
Network providers	Contracted providers with the same scheme to render services for specific network options and benefits. Members are restricted to make use of these providers.

TERMINOLOGY	DEFINITION
Non-CDL chronic conditions	Non-CDL conditions are additional chronic conditions which may be covered by the Scheme, depending on the chosen benefit option. It is not compulsory for the Scheme to fund treatment of these conditions. These are conditions such as gout and acne. Refer to the Comparative Guide for the list of conditions covered per option.
Oncology	Oncology is the branch of medical science dealing with cancer, including the origin, development, diagnosis and treatment of malignant neoplasms of solid organs, non-solid organs and systems in the body.
Over the counter	Medicine that can be obtained from a pharmacy without a prescription, known as self-medication.
Overall annual limit	This means that benefits for services rendered during a year are subjected to an overall annual maximum benefit amount and various sub-limits, where applicable.
Pace range	The Pace range offers comprehensive hospital benefits from Scheme benefits, and additional personal medical savings and benefits to cover extensive out-of-hospital expenses. The options in this category are Pace1, Pace2, Pace3 and Pace4.
Pap smear	A Papanicolaou test (pap smear), also known as a cervical smear, is a quick, painless test used to detect early cell changes in the neck of the womb, which may later progress to cancer.
Per annum	Per annum means from 1 January to 31 December of a year. Should a beneficiary enrol within a financial year, benefit amounts will be pro-rated according to the remaining number of months of the year.
Personal medical savings account (PMSA)	The personal medical savings account (PMSA) account contribution is a fixed monthly amount, which is included in the member's monthly contribution. The credit facility is immediately available at enrolment.
PET scan	Position emission tomography scan.
Pharmaceutical benefit management (PBM)	PBM is the management of medicine benefits for Bestmed members, while ensuring easy access to medicines for all members. The Bestmed medicine programme is managed by qualified pharmacists supported by clinical staff, who ensure that appropriate, cost-effective and quality treatment is provided to all members according to Scheme rules and defined benefits.
Pooled per annum	Benefit available per beneficiary is combined and the total benefit is then available to any member of the family.
Pre-authorisation	Pre-authorisation means benefits for a service must be authorised before it is rendered.
Preferred Provider Negotiators (PPN)/ Optical benefit	PPN will be solely responsible for the optical benefits, claims and payment queries for all our options, excluding Beat1 and 2 options, and as such all calls should be directed to PPN. It is essential that PPN handle the entire process to avoid any confusion by the members.
Prescribed Minimum Benefits (PMBs)	Prescribed Minimum Benefits (PMBs) are a set of minimum benefits which, by law, must be provided to all medical scheme members and include the provision of diagnosis, treatment and costs of ongoing care.

TERMINOLOGY	DEFINITION
Preventative care	Preventative care provides for the benefits of selected out-of-hospital services. Benefits will contribute to protecting the good health of members. Preventative care is important in making sure you detect medical conditions early and so that we can ensure the best care for you in this regard. Bestmed offers preventative care, which covers a number of benefits from the Scheme's risk benefit and not your personal medical savings account (PMSA). General and option-specific exclusions may apply to the various options. Please refer to www.bestmed.co.za for more details.
Radiology	The term is used to refer to scans that are used to diagnose a medical condition.
Registered nurse	Nursing at home by a visiting registered nurse and wound dressings provided at home are only considered under specific clinical circumstances, usually in lieu of hospitalisation and funded from the general risk pool. Private nursing/specialised wound care will be considered on an individual basis. These services must be rendered by a registered nurse with the South African Nursing Council and the private nurse must have a BHF practice number to claim for the service provided.
Rehabilitation services after trauma	Aimed at the recovery of impeded vital functions immediately after trauma, such as stroke or heart attack.
Rhythm range	The Rhythm range offers full hospital benefits with out-of-hospital benefits provided by designated network providers only. This range has two options: Rhythm1 and Rhythm 2.
Scheme tariff	Scheme tariff is the tariff for service as approved by Board of Trustees.
South African Health Products Regulatory Authority (SAHPRA)	SAHPRA is tasked with regulating (monitoring, evaluating, investigating, inspecting and registering) all health products. This includes clinical trials, complementary medicines, medical devices and in vitro diagnostics (IVDs). Furthermore, SAHPRA has the added responsibility of overseeing radiation control in South Africa. SAHPRA's mandate is outlined in the Medicines and Related Substances Act (Act 101 of 1965 as amended), as well as the Hazardous Substances Act (Act 15 of 1973).
Sub-acute	Sub-acute care is provided on an inpatient basis to those individuals needing services that are more intensive than those typically received in skilled nursing facilities, but less intensive than admission in acute hospital care facilities (previously Step-Down facilities). Sub-acute units tend to be housed in skilled nursing facilities or in skilled nursing units.
Supplementary services	Service includes occupational therapy, speech therapy, dietitians, chiropody, masseurs, biokineticists, etc.
Tariff code	It is a description code, indicating the service rendered for a treatment being received and is, therefore, compulsory on all claims or treatment applications. A tariff code is used to give a description of services rendered by a GP in their rooms or in hospital.
Tempo wellness programme	Tempo is our health and wellness programme that assists members in leading a healthier lifestyle and living their best lives. It is a package of benefits and offerings, which gives members access to expert healthcare professionals. Their advice and assistance will help members understand their health risks and improve their quality of life. The Tempo wellness programme is focused on supporting you on your path to improving your health and realising the rewards that come with it.

TERMINOLOGY	DEFINITION
Treatment plan	For every CDL and PMB chronic condition, where medicine is approved, there is a basic treatment plan that is provided. The treatment plan differs from condition to condition and can include consultations, pathology and radiology. These services are paid from Scheme benefits and not from the personal medical savings account (PMSA). For each approved service, there is a maximum allowed per annum.
Types of benefits	
In-hospital benefits:	Accommodation, take-home medication, treatment in mental health and chemical and substance abuse clinics, consultations and procedures, surgical procedures and anaesthetic, organ transplants, supplementary services, confinements etc.
Out-of-hospital benefits:	GPs and specialists, diabetes primary care, basic and specialised dentistry, apparatus like hearing aids, supplementary services, wound care, optometry, basic and specialised radiology, rehabilitation after trauma, HIV/AIDS, oncology, medicine (CDL and non-CDL, OTC, biologicals.
Preventative benefits:	Flu, pneumonia, HPV, HIB vaccines, paediatric immunisations, female contraceptives, Back and neck rehabilitation programmes, preventative dentistry, mammogram, pap smear, PSA screenings.
Wound care	Specialised wound care therapy, including dressings and negative pressure wound therapy (NPWT) treatment and related nursing services are included in Bestmed's provider network. Practice number is required to claim for the service provided.

CONTACT DETAILS

CLIENT SERVICES
Tel: +27 (0)86 000 2378
Email: service@bestmed.co.za

HIV/AIDS CARE PROGRAMME
Tel: +27 (0)86 000 2378 request x3333
Email: mhc@bestmed.co.za

BESTMED HIV/AIDS MANAGED CARE ORGANISATION

LIFESENSE
Tel: +27 (0)86 050 6080
Email: enquiry@lifesensedm.com

BESTMED DSP PHARMACIES
Please refer to the Bestmed website, www.bestmed.co.za, for network pharmacies in your area.

ONCOLOGY CARE PROGRAMME
Tel: +27 (0)86 000 2378 request x3333
Email: oncology@bestmed.co.za

COMPLAINTS
Tel: +27 (0)86 000 2378
Email: escalations@bestmed.co.za
(Subject box: Manager, escalated query)
Postal address:
PO Box 2297,
Pretoria, Gauteng, 0001

CMS ESCALATIONS
Should an issue remain unresolved with the Scheme, members can escalate to the Council for Medical Schemes (CMS) Registrar's office:

Email: complaints@medicalschemes.co.za

Postal Address:
Private Bag X34, Hatfield, 0028

Physical Address:
Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue,
Eco Park, Centurion, 0157

REGIONAL OFFICES

Pretoria (Head Office)
Tel: +27 (0)86 000 2378
Email: service@bestmed.co.za
Glenfield Office Park,
361 Oberon Avenue,
Faerie Glen, Pretoria, 0081

Cape Town
Tel: +27 (0)21 202 8808
Email: service@bestmed.co.za
Belvedere Office Park
Suite GE003, Portion Ground Floor
Block E, Bella Rosa Street
Bellville, Cape Town, 7550

Durban
Tel: +27 (0)31 279 5420
Email: service@bestmed.co.za
Unit 8, Office 1,
Pencarrow Park,
Pencarrow Crescent,
La Lucia Ridge, 4051

Gqeberha (Port Elizabeth)
Tel: +27 (0)41 363 8921
Email: service@bestmed.co.za
Corner of Carnarvon Place and Humewood Road,
Building 3, Ground Floor, Humerail,
Gqeberha, 6001

Nelspruit

Tel: +27 (0)13 101 0280
Email: service@bestmed.co.za
Crossing Office Block,
Level 1, Block E,
Crossing Shopping Centre,
Nelspruit, 1200.

Polokwane
Tel: +27 (0)86 000 2378
Email: service@bestmed.co.za
Unit 3 Tobara Place,
9 Watermelon Street,
Platinum Park, Bendor,
Polokwane, 0699

HOSPITAL AUTHORISATION
Tel: 080 022 0106
Email: authorisations@bestmed.co.za

CHRONIC MEDICINE
Tel: 086 000 2378
Email: medicine@bestmed.co.za

CLAIMS
Tel: 086 000 2378
Email: service@bestmed.co.za (queries)
claims@bestmed.co.za (claim submissions)

MATERNITY CARE
Tel: 012 472 6797
Email: maternity@bestmed.co.za

WALK-IN FACILITY
Block A, Glenfield Office Park,
361 Oberon Avenue, Faerie Glen,
Pretoria, 0081, South Africa

POSTAL ADDRESS
PO Box 2297, Arcadia,
Pretoria, 0001, South Africa

NETCARE 911
Tel: 082 911
Email: customer.service@netcare.co.za
(queries)

INTERNATIONAL MEDICAL TRAVEL INSURANCE

AZOZA
Tel: 0861 838 333
Claims and emergencies:
assist@azoza.co.za
Travel registrations:
bestmed-assist@linkham.com

PMB
Tel: 086 000 2378
Email: pmb@bestmed.co.za

BESTMED ETHICS AND FRAUD HOTLINE, OPERATED BY ADVANCE CALL
Should you be aware of any fraudulent, corrupt or unethical practices involving Bestmed, members, service providers or employees, please report this anonymously to Advance Call.

Hotline:	0800 111 627
WhatsApp:	0860 004 004
SMS:	48691
Hotmail:	bestmed@behonest.co.za
Free post:	BNT165, Brooklyn Square, 0075
Website & chat:	www.behonest.co.za

086 000 2378
service@bestmed.co.za
068 376 7212
www.bestmed.co.za
Bestmed Medical Scheme
Bestmed Medical Scheme

For a more detailed overview of your benefit option and to receive a membership guide please contact service@bestmed.co.za

Disclaimer: All the 2027 product information appearing in this brochure is provided without a representation or warranty whatsoever, whether expressed or implied, and no liability pertaining thereto will attach to Bestmed Medical Scheme. All information regarding the 2027 benefit options and accompanying services including information in respect of the terms and conditions or any other matters will only be valid once approved by the Registrar of Medical Schemes and may change without notice having due regard to further advice from the Council for Medical Schemes. Please note that should a dispute arise, the registered Rules, as approved by the Registrar of Medical Schemes, shall prevail.

Please visit www.bestmed.co.za for the complete liability and responsibility disclaimer for Bestmed Medical Scheme as well as the latest Scheme Rules.

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