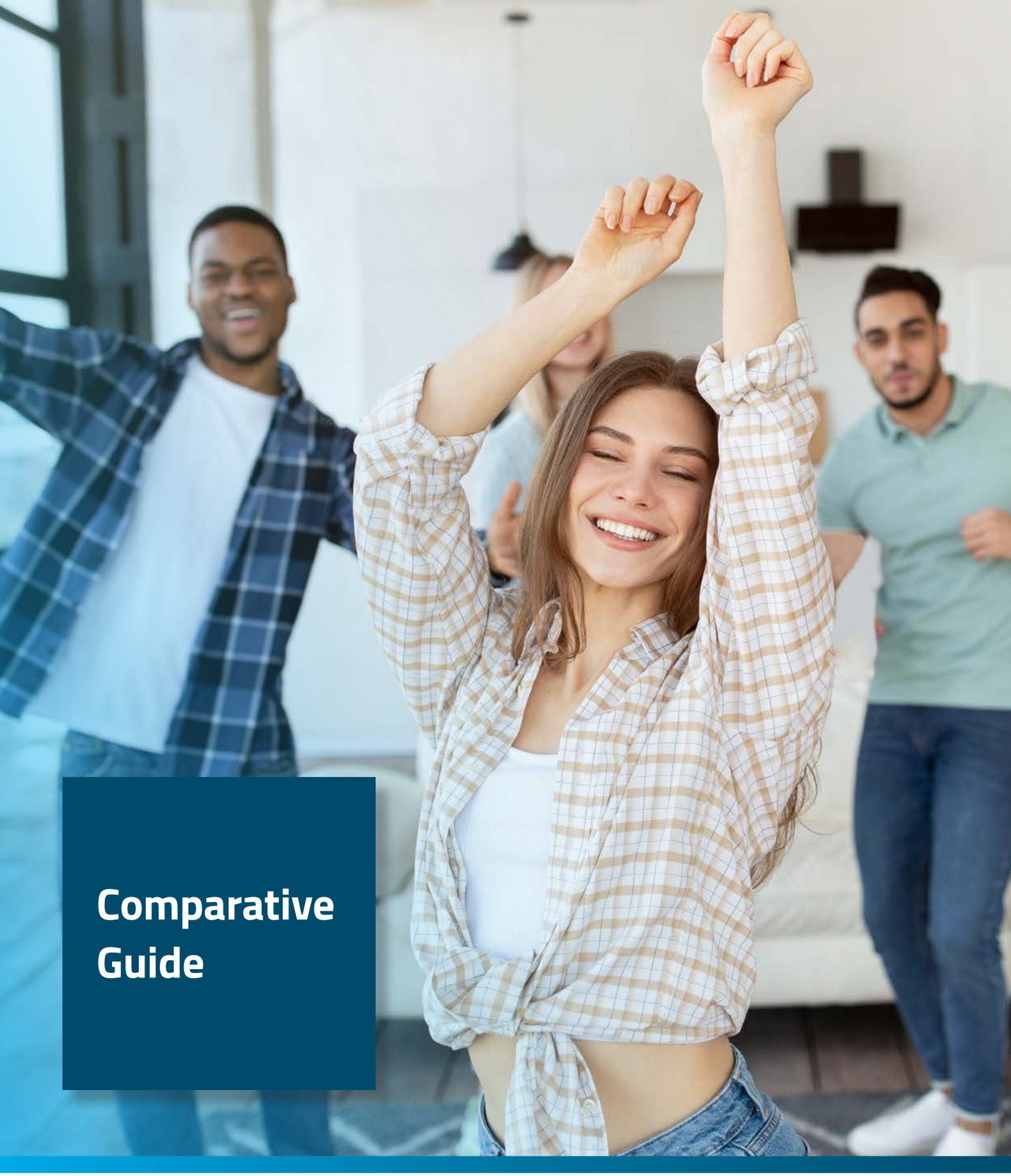


Comparative Guide

2024

bestMed

personally yours

Contents

Why choose Bestmed?

Bestmed is *Personally Yours*

- **Excellent preventative care benefits** on all options, including pneumonia and flu vaccines, female contraceptives, paediatric immunisations, HPV vaccinations for females 9 to 26 years old, and a mammogram every 24 months for females older than 40 years.
- Children qualify for **child dependant rates up to the age of 24** and **students up to the age of 26 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 Afrika Orange Index** in 2020 and 2022.
- **More than 18 000 network provider** agreements.
- **Country-wide geographical healthcare network coverage.**

Free wellness programme: Tempo

- Live life at your Tempo with free online Fitness, Nutrition and Emotional Wellbeing Journeys, easily accessible via the Tempo portal available on the Bestmed App and Member portal on our website.
- The Health Assessment (HA), available online for your convenience, will help you assess your overall health and wellness status.
- An established network of healthcare professionals supporting your physical, nutritional and mental wellbeing.
- Access to a wealth of information, practical tools and support via the online Tempo Journeys (Fitness, Nutrition, and Emotional Wellbeing) - to give you full control over living your best life.
- Fully funded in-person and/or virtual consultations with Bestmed Tempo partner biokineticists and dietitians.

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:

- Access to a digital version of your membership card
- Find a service provider
- Submit a claim
- Check your available benefits
- Email your membership card to service providers
- Check your Health Assessment 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

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 Health Assessment, 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 Health Assessment (HA) is available for completion via the Tempo portal on the Bestmed App or website. Your data will reflect on the Tempo partner pharmacies' (Clicks, Dis-Chem, and Van Heerden Pharmacy) systems for the registered nurse to also complete the biometric screening portion of the assessment. The completed assessment will give you an important overview of your health status, and guide you in terms of which areas require focus to improve your health.

Should you choose to make use of the Tempo Fitness and/or Nutrition programme benefits, the results will also be shared with our Tempo partner biokineticists and dietitians automatically.

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 Health Assessment (HA) for adults (beneficiaries 16 years and older) which includes:**
  - The Tempo lifestyle questionnaire
  - Blood pressure check
  - Cholesterol check
  - Glucose check
  - Height, weight and waist circumference
- **Tempo Fitness and Nutrition programmes (beneficiaries 16 and older):**

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

  These fitness benefits are intended to assist you on your Tempo **Get Active Journey**.

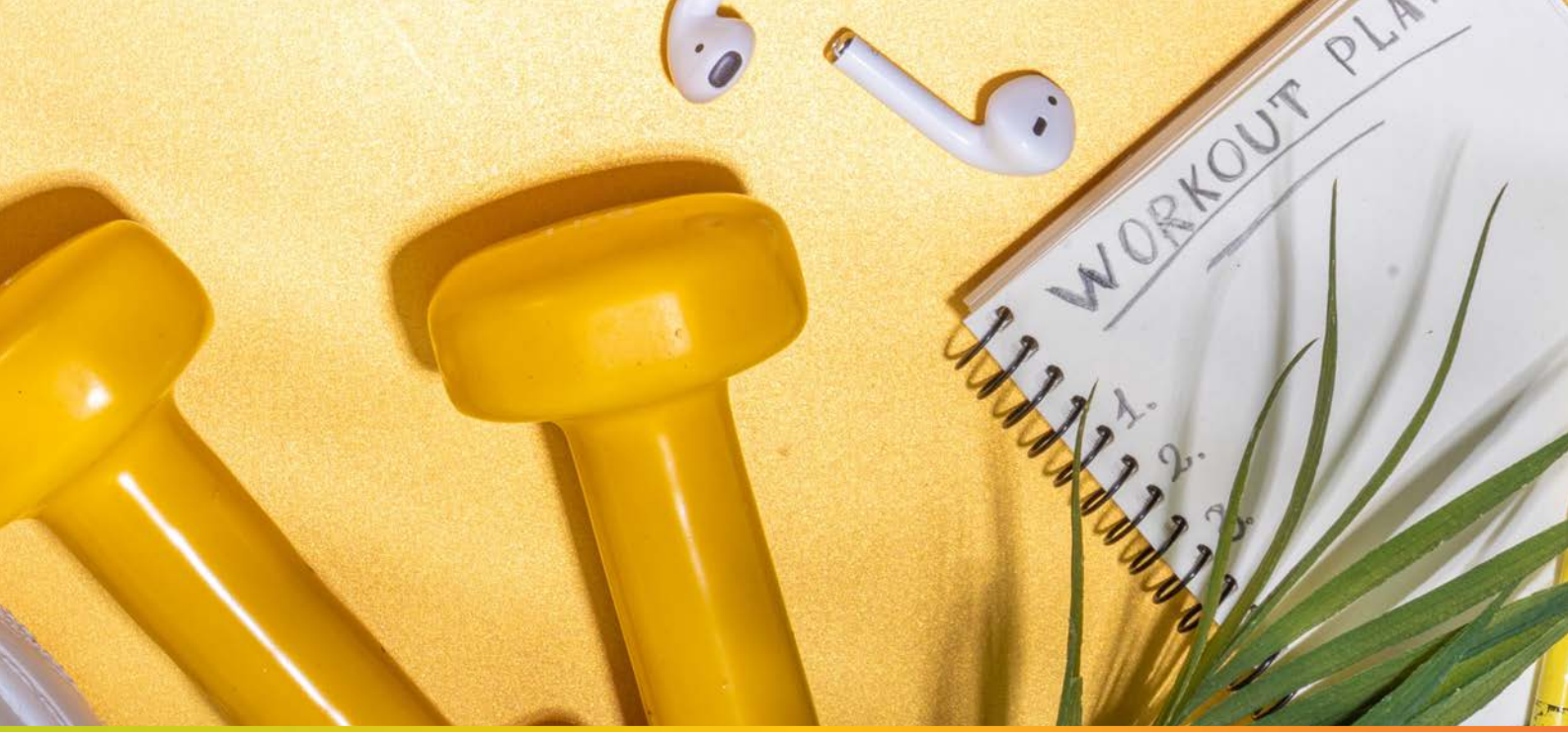
  Nutrition:
  - 1 x **(face-to-face)** nutrition assessment at a Tempo partner dietitian
  - 1 x follow-up **(virtual or face-to-face)** consult to obtain your personlised healthy-eating plan from the Tempo partner dietitian

  These nutrition benefits are intended to assist you on your Tempo **Nutritional Health Journey**.

BESTMED TEMPO JOURNEYS ONLINE*

Track your fitness and nutritional progress online

Designed with each of our members in mind, we will provide members with access to their **Get Active Journey** (Fitness) and **Nutritional Health Journey** online via both the Bestmed App and the member portal on the Bestmed website. It is recommended that you firstly complete your HA, available online on the Get Active and Nutritional Health Journey platform, to guide the next steps of your journey to being your best self. Some of the



features and benefits you can look forward to on the online journeys:

- set personal goals.
- track your exercise (by syncing with your fitness device).
- make dietary changes as advised by the Tempo dietitian.
- access the On-demand exercise classes wherever and whenever you choose.
- take part in challenges and invite friends and family who are Bestmed members to join in.

You will not be required to make use of the Tempo dietitian or biokineticist to gain access to your online journeys. You can follow your own progress without consulting any of the Tempo providers. It would, however, be advised that you complete your Health Assessment (HA) before you commence with your respective online Tempo journeys.

Your Emotional Wellbeing Journey

In addition to the Get Active Journey (Fitness) and Nutritional Health Journey, that are now available online, you will have access to your **Emotional Wellbeing Journey**. This journey was developed by qualified psychologists and healthcare providers, and will assist you to identify the difference between feeling a bit "down" and when what you are feeling requires professional assistance from a qualified psychologist. The Emotional Wellness Journey provides you with access to:

- lifestyle related information that will help you deal with life's changes and curve balls.
- practical challenges that will enable you to practice the new skills you have to acquire to progress from your current emotional and mental state to your desired state.

Emotional Wellbeing Journey (via the Bestmed App and website):

- Two Emotional Wellbeing-related Assessments that can provide an indication of whether the participant experiences symptoms of depression and/or anxiety (for beneficiaries 21 years and older).
- Access to the educational information, challenges, recordings, videos, and support group details (for beneficiaries 16 years and older).

Bestmed understands that mental healthcare is extremely important to our members. We will provide you with the contact details of the mental health practitioners within our network on this journey - should you wish to consult with one of them face-to-face or virtually. Please note that the cost of these consultations will be payable from your available savings account or your day-to-day benefits, should your option make provision for supplementary benefits.

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 savings 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 medical savings account.	▪ 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 medical savings account.		▪ 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 your medical savings account first, once depleted, from your day-to-day benefit.

- Benefits relating to conditions that meet the criteria for PMBs will be covered in full when using DSPs, this will not affect your savings (annual or vested) for applicable options.

BEAT NETWORK PLAN OPTION

- 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 R13 732 will apply.

In-hospital benefits

The non-network option provides you with access to any hospital of your choice. This is the standard option. The network option provides 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 savings.

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) and theatre fees	100% Scheme tariff.				
Take-home medicine	100% Scheme tariff. Medicine limited to 7 days.				
Biological medicine during hospitalisation	Limited to R11 099 per family per annum. Subject to pre-authorisation and funding guidelines.	Limited to R16 648 per family per annum. Subject to pre-authorisation and funding guidelines.	Limited to R22 197 per family per annum. Subject to pre-authorisation and funding guidelines.		Limited to R27 746 per family per annum. Subject to pre-authorisation and funding guidelines.
Treatment in mental health facilities	100% Scheme tariff. Limited to a maximum of 21 days per beneficiary per annum.				
Treatment of chemical and substance abuse	100% Scheme tariff. Limited to 21 days or R37 352 per beneficiary per annum. Subject to network facilities.				
Consultations and procedures	100% Scheme tariff.				
Surgical procedures and anaesthetics	100% Scheme tariff.	100% Scheme tariff.	100% Scheme tariff.		100% Scheme tariff.
Organ transplants	100% Scheme tariff (PMBs only).				
Stem cell transplants	100% Scheme tariff (PMBs only).				
Major maxillofacial surgery, strictly related to certain conditions	No benefit. (PMBs only).		100% Scheme tariff. Limited to R14 969 per family per annum.		100% Scheme tariff. Limited to R15 244 per family per annum.

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Dental and oral surgery (in or out of hospital)	PMBs only at DSP day hospitals.	PMBs only at DSP day hospitals. **Beneficiaries 7 years and younger** Limited to R6 071 per family per annum. **Beneficiaries over 7 years** Dental surgical procedures paid from savings for procedures performed in the doctor's rooms only.	Limited to R9 338 per family per annum.		Limited to R11 673 per family per annum.
Prosthesis (subject to preferred providers and DSPs, otherwise limits and co-payments apply)	100% Scheme tariff. Limited to R91 183 per family per annum.		100% Scheme tariff. Limited to R92 145 per family per annum.		100% Scheme tariff. Limited to R112 478 per family per annum.
Prosthesis – Internal **Note: Sub-limits subject to availability of overall prosthesis limit.** ***Functional: Items used to replace or augment an impaired bodily function.**	Sub-limits per beneficiary per annum: ▪ *Functional limited to R32 550. ▪ Vascular R52 500. ▪ Pacemaker (dual chamber) R49 711. ▪ Endovascular and catheter-based procedures – no benefit. ▪ Spinal including artificial disc R36 394. ▪ Drug-eluting stents – PMBs and DSPs apply. ▪ Mesh R12 772. ▪ Gynaecology/urology R10 437. ▪ Lens implants R7 964 a lens per eye.		Sub-limits per beneficiary per annum: ▪ *Functional limited to R33 600. ▪ Vascular R63 000. ▪ Pacemaker (dual chamber) R49 711. ▪ Endovascular and catheter-based procedures – no benefit. ▪ Spinal including artificial disc R36 528. ▪ Drug-eluting stents – PMBs and and DSPs apply ▪ Mesh R12 838. ▪ Gynaecology/urology R10 603. ▪ Lens implants R7 964 a lens per eye.		Sub-limits per beneficiary per annum: ▪ *Functional limited to R35 700. ▪ Vascular R68 250. ▪ Pacemaker (dual chamber) R65 092. ▪ Endovascular and catheter-based procedures – no benefit. ▪ Spinal including artificial disc R38 864. ▪ Drug-eluting stents R21 835. ▪ Mesh R14 420. ▪ Gynaecology/urology R10 575. ▪ Lens implants R8 239 a lens per eye.
Exclusions (Prosthesis sub-limit subject to preferred provider, otherwise limits and co-payments apply).	Joint replacement surgery (except for PMBs). PMBs subject to prosthesis limits: ▪ Hip replacement and other major joints R38 313. ▪ Knee replacement R47 240. ▪ Other minor joints R14 695.		Joint replacement surgery (except for PMBs). PMBs subject to prosthesis limits: ▪ Hip replacement and other major joints R38 589. ▪ Knee replacement R47 748. ▪ Other minor joints R14 695.		Joint replacement surgery (except for PMBs).PMBs subject to prosthesis limits: ▪ Hip replacement and other major joints R39 962. ▪ Knee replacement R53 090. ▪ Other minor joints R16 313.
Prosthesis – External	No benefit (PMBs only).				Limited to R27 053 per family. Includes artificial limbs, limited to one (1) limb every 60 months.
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.				
Orthopaedic and medical appliances	100% Scheme tariff.				
Pathology	100% Scheme tariff.				
Basic radiology	100% Scheme tariff.				
Specialised diagnostic imaging (including MRI scans, CT scans and isotope studies).	100% Scheme tariff.				
Oncology	100% Scheme tariff. Subject to pre-authorisation and DSPs.				
Peritoneal dialysis and haemodialysis	100% Scheme tariff. Subject to pre-authorisation and DSPs.				
Confinements (birthing)	100% Scheme tariff.				
HIV/AIDS	100% Scheme tariff. Subject to pre-authorisation and DSPs.				

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Refractive surgery and other procedures done to improve or stabalise vision (except cataracts)	PMBs only.		100% Scheme tariff. Subject to pre-authorisation and protocols. Limited to R9 613 per eye.		100% Scheme tariff. Subject to pre-authorisation and protocols. Limited to R10 850 per eye.
Midwife-assisted births	100% Scheme tariff.				
Supplementary services	100% Scheme tariff.				
Alternative to hospitalisation (i.e. procedures done in the doctor's rooms)	100% Scheme tariff.				
Advanced illness benefit	100% Scheme tariff, limited to R66 591 per beneficiary per annum. Subject to available benefit, pre-authorisation and treatment plan.				100% Scheme tariff, limited to R99 887 per beneficiary per annum. Subject to available benefit, pre-authorisation and treatment plan.
Day procedures	Day procedures performed in a day hospital by a DSP provider will be funded at 100% network or Scheme tariff. A co-payment of R2 625 will be incurred per event if a day procedure is voluntarily done by a non-DSP provider, or if the procedure is done in an acute hospital that is not a day hospital. If the provider is a DSP and does not work in a day hospital, the procedure will be paid in full if it is done in an acute hospital.				
International medical travel cover	▪ Holiday travel: Limited to 45 days and R500 000 cover for travel to the USA. All other countries covered up to 90 days, with R3 million per family, i.e. member and dependants. ▪ Business travel: Limited to 45 days and R500 000 cover for travel to the USA. All other countries covered up to 45 days, with R3 million per family, i.e. member and dependants.				
Co-payments	Co-payment for voluntary use of non-network hospital R13 732. For network options.				

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 Mediscor Reference Price (MRP).

Members are required to obtain pre-authorisation for all planned treatments and/or procedures.

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Overall day-to-day limit	Not applicable.				M = R14 831, M1+ = R29 661.
Family Practitioner (FP) and specialist consultations	No benefit.	Savings account.	Savings account.	Savings account.	Savings first. Limited to M = R3 777, M1+ = R6 728. (Subject to overall day-to-day limit)
Basic and specialised dentistry	No benefit.	**Basic:** Preventative benefit or savings account. **Specialised:** Savings account. **Orthodontic:** Subject to pre authorisation.			Savings first. Limited to M = R6 534, M1+ = R13 124. (Subject to overall day-to-day limit) Orthodontics are subject to pre-authorisation.
Medical aids, apparatus and appliances including wheelchairs	No benefit.	Savings account.	Savings account.	Savings account.	Savings first. Limited to R13 321 per family. Includes repairs to artificial limbs. 100% Scheme tariff. (Subject to overall day-to-day limit).
Hearing aids are subject to pre-authorisation	No benefit.	Savings account.	Savings account.	Savings account.	Limited to R12 208 per family every 24 months. 100% Scheme tariff. Subject to quotation, motivation and audiogram.
Supplementary services	No benefit.	Savings account.	Savings account.	Limited to R2 000 per family per annum. Thereafter, savings account.	Savings first. Limited to M = R5 768, M1+ = R11 714. (Subject to overall day-to-day limit)

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Wound care benefit (incl. dressings, negative pressure wound therapy -NPWT- treatment and related nursing services -out-of-hospital)	100% Scheme tariff. Limited to R4 079 per family.				Savings first. 100% Scheme tariff. Limited to R5 768 per family. (Subject to overall day-to-day limit)
Basic radiology and pathology	No benefit.	Savings account.			Savings first. Limited to M = R3 776, M1+ = R7 690. (Subject to overall day-to-day limit)
Specialised diagnostic imaging (Including MRI scans, CT scans and isotope studies. PET scans only included as indicated per option)	100% Scheme tariff. Limited to R6 179 per family (excluding PET scans). Limited to one (1) scan per lumbar and cervical spine region per beneficiary per annum.		100% Scheme tariff. Limited to R12 979 per family (excluding PET scans). Limited to one (1) scan per lumbar and cervical spine region per beneficiary per annum.		100% Scheme tariff. Limited to R19 638 per family. Limited to one (1) scan per lumbar and cervical spine region per beneficiary per annum.
Rehabilitation services after trauma	PMBs only. Subject to pre-authorisation and DSPs.				100% Scheme tariff.
Managed Healthcare - Back and neck preventative programme	Benefits payable at 100% of contracted fee. Subject to pre-authorisation, protocols and DSPs.				
HIV/AIDS	100% Scheme tariff. Subject to pre-authorisation and DSPs.				
Oncology	Oncology programme at 100% of Scheme tariff. Subject to pre-authorisation and DSP.				
Peritoneal dialysis and haemodialysis	100% Scheme tariff. Subject to pre-authorisation and DSPs.				
Optometry benefit	No benefit.	Savings account.	Savings account.	Benefits available every 24 months from date of service. **Network Provider** Consultation - One (1) per beneficiary. Frame = R 860 covered AND 100% of cost of standard lenses (single vision OR bifocal OR multifocal) OR Contact lenses = R1 630 OR **Non-network Provider** Consultation - R350 fee at non-network provider Frame = R598 AND Single vision lenses = R210 OR Bifocal lenses = R445 OR Multifocal lenses = R1 000 In lieu of glasses members can opt for contact lenses, limited to R1 630	Benefits available every 24 months from date of service. **Network Provider** Consultation - One (1) per beneficiary. Frame = R1 000 covered AND 100% of cost of standard lenses (single vision OR bifocal OR multifocal) OR Contact lenses = R1 840 OR **Non-network Provider** Consultation - R365 fee at non-network provider Frame = R750 AND Single vision lenses = R215 OR Bifocal lenses = R460 OR Multifocal lenses = R982.50 In lieu of glasses members can opt for contact lenses, limited to R1 840

Medicine

Note: Benefits mentioned below may be subject to pre-authorisation, clinical protocols, preferred providers, designated service providers, formularies, funding guidelines, the Mediscor Reference Price (MRP), and the exclusions referred to in Annexure C of the registered Rules. 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 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
CDL & PMB chronic medicine*	100% Scheme tariff. Co-payment of 30% for non-formulary medicine.				100% Scheme tariff. Co-payment of 20% for non-formulary medicine.

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Non-CDL chronic medicine	No benefit.		5 conditions. 80% Scheme tariff. Limited to M = R3 983, M1+ = R8 102. Co-payment of 30% for non-formulary medicine.		9 conditions. 90% Scheme tariff. Limited to M = R8 748, M1+ = R17 496. Co-payment of 20% for non-formulary medicine.
Biologicals and other high-cost medicine	PMBs only as per funding protocol. Subject to pre-authorisation.				Subject to pre-authorisation. 100% Scheme tariff. Co-payment of 20% for non-formulary medicine.
Acute medicine	No benefit.	Savings account.			Savings first. Limited to M = R3 337, M1+ = R6 742. (Subject to overall day-to-day limit)
Over-the-counter (OTC) medicine **Includes sunscreen, vitamins and minerals with NAPPI codes on Scheme formulary**	No benefit.	Savings account.			**Member choice: R1 110 OTC limit per family OR Access to full savings for OTC purchases (after R1 110 limit) = self-payment gap accumulation. Subject to available savings.

*For Beat3 and Beat4, approved medicines for the following conditions are not subject to the non-CDL limit: organ transplant, chronic renal failure, multiple sclerosis, haemophilia. Medicine claims will be paid directly from Scheme risk.
**The default OTC choice is 1. R1 110 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, formularies, funding guidelines and the Mediscor Reference Price (MRP).

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
Preventative care benefits **Note: Refer to Scheme rules for funding criteria applicable to each preventative care benefit.**	▪ Flu vaccines. ▪ Pneumonia vaccines. ▪ Three baby growth and development assessments per year for children 0-2 years. ▪ Female contraceptives – R2 678 per beneficiary per year. ▪ Pap smear – ages 18 and above, every 24 months. ▪ HPV vaccinations. ▪ Mammogram – females ages 40 and above, every 24 months.	▪ Flu vaccines. ▪ Pneumonia vaccines. ▪ Travel vaccines. ▪ Paediatric immunisations. ▪ Three baby growth and development assessments per year for children 0-2 years. ▪ Female contraceptives – R2 678 per beneficiary per year. ▪ Intrauterine device (IUD) insertion (consultation and procedure) by a FP or gynaecologist. Once every 5 years. ▪ Preventative dentistry. ▪ Pap smear – ages 18 and above, every 24 months. ▪ HPV vaccinations. ▪ Mammogram – females ages 40 and above, every 24 months. ▪ PSA Screening – males ages 50 years and above, every 24 months.			▪ Flu vaccines. ▪ Pneumonia vaccines. ▪ Travel vaccines. ▪ Paediatric immunisations. ▪ Three baby growth and development assessments per year for children 0-2 years. ▪ Female contraceptives – R2 678 per beneficiary per year. ▪ Intrauterine device (IUD) insertion (consultation and procedure) by a FP or gynaecologist. Once every 5 years. ▪ Preventative dentistry. ▪ Mammogram – females ages 40 and above, every 24 months. ▪ HPV vaccinations. ▪ PSA Screening – males ages 50 years and above, every 24 months. ▪ Pap smear (procedure and consultation) – ages 18 and above, every 24 months.

	BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
PREVENTATIVE DENTISTRY					
General full-mouth examination by a general dentist (incl. gloves and use of sterile equipment)	No benefit	Once a year for members 12 years and above. Twice a year for members under 12 years.			
Full-mouth intra-oral radiographs	No benefit	Once every 36 months for all ages.			
Intra-oral radiograph	No benefit	Two (2) photos per year for all ages.			
Scaling and/or polishing	No benefit	Twice per year (i.e. every 6 months from the date of service) for all ages.			
Fluoride treatment	No benefit	Twice per year (i.e. every 6 months from the date of service) for all ages.			
Fissure sealing	No benefit	Up to and including 21 years. Frequency must be in accordance with accepted protocol.			
Space maintainers	No benefit	Once per space during the primary and mixed denture stage.			

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 pre-authorisation, clinical protocols, preferred providers, designated service providers, formularies, funding guidelines and the Mediscor Reference Price (MRP).

BEAT1	BEAT2	BEAT3	BEAT3 PLUS	BEAT4
100% Scheme tariff. Subject to the following benefits: **Consultations:** ▪ 6 antenatal consultations at a FP OR gynaecologist OR midwife. **Ultrasounds:** ▪ 1 x 2D ultrasound scan at 1st trimester (between 10 to 12 weeks) at a FP OR gynaecologist OR radiologist. ▪ 1 x 2D ultrasound scan at 2nd trimester (between 20 to 24 weeks) at a FP OR gynaecologist OR radiologist.		100% Scheme tariff. Subject to the following benefits: **Consultations:** ▪ 9 antenatal consultations at a FP OR gynaecologist OR midwife. ▪ 1 post-natal consultation at a FP OR gynaecologist OR midwife. **Ultrasounds:** ▪ 1 x 2D ultrasound scan at 1st trimester (between 10 to 12 weeks) at a FP OR gynaecologist OR radiologist. ▪ 1 x 2D ultrasound scan at 2nd trimester (between 20 to 24 weeks) at a FP OR gynaecologist OR radiologist. **Supplements:** ▪ Any item categorised as a maternity supplement can be claimed up to a maximum of R133 per claim, once a month, for a maximum of 9 months.		

Contributions

		BEAT1 N	BEAT1	BEAT2 N	BEAT2	BEAT3 N	BEAT 3	BEAT3 PLUS	BEAT4
Medical Savings Account		N/A		16%		15%		25%	14%
Principal Member	Risk	R1 873	R2 082	R1 923	R2 138	R2 849	R3 165	R3 225	R5 211
	Savings	R0	R0	R366	R407	R503	R559	R1 075	R848
	Total	**R1 873**	**R2 082**	**R2 289**	**R2 545**	**R3 352**	**R3 724**	**R4 300**	**R6 059**
Adult Dependant	Risk	R1 456	R1 616	R1 494	R1 660	R2 032	R2 258	R2 318	R4 303
	Savings	R0	R0	R285	R316	R359	R398	R773	R701
	Total	**R1 456**	**R1 616**	**R1 779**	**R1 976**	**R2 391**	**R2 656**	**R3 091**	**R5 004**
Child Dependant	Risk	R789	R875	R809	R900	R1 006	R1 117	R1 177	R1 288
	Savings	R0	R0	R154	R171	R177	R197	R392	R210
	Total	**R789**	**R875**	**R963**	**R1 071**	**R1 183**	**R1 314**	**R1 569**	**R1 498**
Maximum contribution child dependants*		3							
Recognition of a child dependant		Child dependants under the age of 24 years and registered students up to the age of 26 years, in accordance with the Rules, are regarded as child dependants.							

* You only pay for a maximum of three children. Any additional children join as beneficiaries of the Scheme at no additional cost.

ABBREVIATIONS

CDL = Chronic Disease List; DBC = Documentation Based Care (back rehabilitation programme); DSP = Designated Service Provider; FP = Family Practitioner or Doctor; HPV = Human Papilloma Virus; M = Member; M1+ = Member and family; MRP = Mediscor Reference Price; PMB = Prescribed Minimum Benefit; PPN = Preferred Provider Negotiators; PSA = Prostate Specific Antigen.

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 annual savings 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 savings.

- Benefits relating to conditions that meet the criteria for PMBs will be covered in full when using DSPs, this will not affect your savings (annual or vested).

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 savings.

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) and theatre fees	100% Scheme tariff.			
Take-home medicine	100% Scheme tariff. Medicine limited to 7 days.			
Biological medicine during hospitalisation	Limited to R33 296 per family per annum. Subject to pre-authorisation and funding guidelines.	Please refer to the Biological and other high-cost medicine benefit under Medicine on p.17 of this guide.		
Treatment in mental health facilities	100% Scheme tariff. Limited to a maximum of 21 days per beneficiary per annum.			
Treatment of chemical and substance abuse	100% Scheme tariff. Limited to 21 days or R37 352 per beneficiary per annum. DSPs apply.			
Consultations and procedures	100% Scheme tariff.			
Surgical procedures and anaesthetics	100% Scheme tariff.			
Organ transplants	100% Scheme tariff. (PMBs only)			
Stem cell transplants	100% Scheme tariff (PMBs only).			
Major maxillofacial surgery, strictly related to certain conditions	100% Scheme tariff. Limited to R15 105 per family per annum.	100% Scheme tariff.		
Dental and oral surgery (in or out of hospital)	Limited to R9 338 per family per annum.	Limited to R15 518 per family per annum.	Limited to R19 500 per family per annum.	Limited to R23 345 per family per annum.
Overall annual prosthesis limit (subject to preferred provider, otherwise limits and co-payments apply)	100% Scheme tariff. Limited to R104 366 per family.	100% Scheme tariff. Limited to R134 028 per family.	100% Scheme tariff. Limited to R134 715 per family.	100% Scheme tariff. Limited to R155 450 per family.

	PACE1	PACE2	PACE3	PACE4
Prosthesis – Internal **Note: Sub-limits subject to availability of overall prosthesis limit.** ***Functional: Items used to replace or augment an impaired bodily function.**	Sub-limits per beneficiary per annum: ▪ *Functional limited to R35 700. ▪ Vascular R68 250. ▪ Pacemaker (dual chamber) R64 955. ▪ Endovascular and catheter-based procedures – no benefit. ▪ Spinal including artificial disc R38 038. ▪ Drug-eluting stents – PMBs and DSPs apply. ▪ Mesh R14 282. ▪ Gynaecology/urology R10 299. ▪ Lens implants R7 828 a lens per eye.	Sub-limits per beneficiary per annum: ▪ *Functional limited to R37 800. ▪ Vascular R68 250. ▪ Pacemaker (dual chamber) R72 438. ▪ Spinal including artificial disc R67 193. ▪ Drug-eluting stents R21 972. ▪ Mesh R21 972. ▪ Gynaecology/urology R16 409. ▪ Lens implants R14 090 a lens per eye. ▪ Joint replacements: - Hip replacement and other major joints R60 353. - Knee replacement R70 035. - Other minor joints R26 022.	Sub-limits per beneficiary per annum: ▪ *Functional limited to R37 800 ▪ Vascular R72 450 ▪ Pacemaker (dual chamber) R72 438. ▪ Spinal including artificial disc R67 321. ▪ Drug-eluting stents R21 972. ▪ Mesh R21 972. ▪ Gynaecology/urology R16 479. ▪ Lens implants R14 090 a lens per eye. ▪ Joint replacements: - Hip replacement and other major joints R60 422. - Knee replacement R70 378. - Other minor joints R26 022.	Sub-limits per beneficiary per annum: ▪ *Functional limited to R42 000. ▪ Vascular R72 450 ▪ Pacemaker (dual chamber) R72 438. ▪ Spinal including artificial disc R77 732. ▪ Drug-eluting stents R25 886. ▪ Mesh R22 796. ▪ Gynaecology/urology R18 814. ▪ Lens implants R20 832 a lens per eye. ▪ Joint replacements: - Hip replacement and other major joints R69 555. - Knee replacement R80 540. - Other minor joints R25 886.
Exclusions (Prosthesis sub-limit subject to preferred provider, otherwise limits and co-payments apply)	Joint replacement surgery (except for PMBs). PMBs subject to prosthesis limits: ▪ Hip replacement and other major joints R38 725. ▪ Knee replacement R51 497. ▪ Other minor joints R15 999.	Not applicable.		
Prosthesis – External	Limited to R26 504 per family per annum.	Limited to R31 584 per family per annum.	Limited to R31 723 per family per annum.	Limited to R35 842 per family per annum.
Orthopaedic and medical appliances	100% Scheme tariff.			
Pathology	100% Scheme tariff.			
Basic radiology	100% Scheme tariff.			
Specialised diagnostic imaging (including MRI scans, CT scans and isotope studies).	100% Scheme tariff.			
Oncology	Oncology programme. 100% of Scheme tariff. Subject to pre-authorisation and DSPs.		Oncology programme. 100% of Scheme tariff. Subject to pre-authorisation and DSPs. Access to extended protocols.	
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 the surgeon and anaesthetist)	No benefit			100% Scheme tariff. R55 493 per family per annum. Theatre and hospital cost will be funded from Scheme risk. Subject to funding protocols, pre-authorisation.
Peritoneal dialysis and haemodialysis	100% Scheme tariff. Subject to pre-authorisation and DSPs.			
HIV/AIDS	100% Scheme tariff. Subject to pre-authorisation and DSPs.			
Confinements (birthing)	100% Scheme tariff.			
Refractive surgery and other procedures done to improve or stabilise vision (except cataracts)	100% Scheme tariff. Subject to pre-authorisation and protocols. Limited to R10 381 per eye.	100% Scheme tariff. Subject to pre-authorisation and protocols. Limited to R10 848 per eye.	100% Scheme tariff. Subject to pre-authorisation and protocols. Limited to R11 673 per eye.	
Midwife-assisted births	100% Scheme tariff.			
Supplementary services	100% Scheme tariff.			
Alternative to hospitalisation (i.e. procedures done in the doctor's rooms)	100% Scheme tariff.			

	PACE1	PACE2	PACE3	PACE4
Advanced illness benefit	100% Scheme tariff, limited to R83 239 per beneficiary per annum. Subject to available benefit, pre-authorisation and treatment plan.	100% Scheme tariff, limited to R133 182 per beneficiary per annum. Subject to available benefit, pre-authorisation and treatment plan.		
Day procedures	Day procedures performed in a day hospital by a DSP provider will be funded at 100% network or Scheme tariff. A co-payment of R2 625 will be incurred per event if a day procedure is voluntarily done by a non-DSP provider, or if the procedure is done in an acute hospital that is not a day hospital. If the provider is a DSP and does not work in a day hospital, the procedure will be paid in full if it is done in an acute hospital.			
International medical travel cover	▪ Holiday travel: Limited to 45 days and R500 000 cover for travel to the USA. All other countries covered up to 90 days, with R3 million per family, i.e. member and dependants. ▪ Business travel: Limited to 45 days and R500 000 cover for travel to the USA. All other countries covered up to 45 days, with R3 million per family, i.e. member and dependants.			

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 Mediscor Reference Price (MRP).

Members are required to obtain pre-authorisation for all planned treatments and/or procedures. Approved PMBs will be paid from scheme risk.

	PACE1	PACE2	PACE3	PACE4
Overall day-to-day limit	M = R12 607, M1+ = R25 213.	M = R15 750, M1+ = R31 500.	M = R21 047, M1+ = R43 496.	M = R41 472, M1+ = R66 878.
FP and specialist consultations	Savings first. Limited to M = R2 596, M1+ = R5 219. (Subject to overall day-to-day limit)	Savings first. Limited to M = R4 808, M1+ = R9 744. (Subject to overall day-to-day limit)	Savings first. Limited to M = R5 082, M1+ = R10 299. (Subject to overall day-to-day limit)	Limited to M = R6 523, M1+ = R10 575. (Subject to overall day-to-day limit)
Basic and specialised dentistry	Savings first. **Basic:** Preventative benefit or savings account. Limit once savings exceeded.**Specialised:** Savings account then limit. **Orthodontic:** Subject to pre-authorisation. Limited to M = R4 778, M1+ = R9 696. (Subject to overall day-to-day limit)	Savings first. **Basic:** Preventative benefit or savings account. Limit once savings exceeded.**Specialised:** Savings account then limit. **Orthodontic:** Subject to pre-authorisation. Beneficiaries over 18 years of age. Limited to M = R8 009, M1+ = R16 019. (Subject to overall day-to-day limit)	Savings first. **Basic:** Preventative benefit or savings account. Limit once savings exceeded. **Specialised:** Savings account then limit. **Orthodontic:** Subject to pre-authorisation. Beneficiaries over 18 years of age. Limited to M = R8 630, M1+ = R16 089. (Subject to overall day-to-day limit)	Limited to M = R14 403, M1+ = R24 310. (Subject to overall day-to-day limit) **Orthodontic:** Subject to pre-authorisation. Beneficiaries over 18 years of age.
Orthodontic dentistry	Per the benefits specified for Pace1 under Basic and specialised dentistry.	Savings first. 100% Scheme tariff. Subject to pre-authorisation. Limited to R7 769 per event for beneficiaries up to 18 years of age. (Subject to overall day-to-day limit)	Savings first. 100% Scheme tariff. Subject to pre-authorisation. Limited to R9 989 per event for beneficiaries up to 18 years of age. (Subject to overall day-to-day limit)	100% Scheme tariff. Subject to pre-authorisation. Limited to R12 208 per event for beneficiaries up to 18 years of age. (Subject to overall day-to-day limit)
Medical aids, apparatus and appliances	Savings first. 100% Scheme tariff. Limited to R13 321 per family. Includes repairs to artificial limbs. (Subject to overall day-to-day limit).	Savings first. Limited to R12 084 per family. Includes repairs to artificial limbs. (Subject to overall day-to-day limit).		Limited to R12 084 per family. Includes repairs to artificial limbs. (Subject to overall day-to-day limit).
Wheel chairs	Subject to medical apparatus and appliance limits.	Limit on wheelchairs of R16 342 per family per 48 months.		
Hearing aids are subject to pre-authorisation	Limited to R9 252 per family every 24 months. 100% Scheme tariff. Subject to quotation, motivation and audiogram.	Limit of R33 302 per beneficiary every 24 months. Subject to quotation, motivation and audiogram.	Limit of R37 490 per beneficiary every 24 months. Subject to quotation, motivation and audiogram.	Limit of R41 746 per beneficiary every 24 months. Subject to quotation, motivation and audiogram.
Insulin pump (excluding consumables)	No benefit.			100% Scheme tariff. Limited to R48 572 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.		100% Scheme tariff. Limited to R22 197 per family per annum. Subject to pre-authorisation.	100% Scheme tariff. Limited to R27 746 per family per annum. Subject to pre-authorisation.

	PACE1	PACE2	PACE3	PACE4
Supplementary services	Savings first. Limited to M = R5 095, M1+ = R10 575. (Subject to overall day-to-day limit)	Savings first. Limited to M = R3 675, M1+ = R7 350. (Subject to overall day-to-day limit)	Savings first. Limited to M = R3 104, M1+ = R6 523. (Subject to overall day-to-day limit)	Limited to M = R6 523, M1+ = R12 839. (Subject to overall day-to-day limit)
Wound care benefit (incl. dressings, negative pressure wound therapy -NPWT- treatment and related nursing services – out-of-hospital)	Savings first. 100% Scheme tariff. Limited to R4 188 per family. (Subject to overall day-to-day limit)	Savings first. 100% Scheme tariff. Limited to R7 535 per family. (Subject to overall day-to-day limit)	Savings first. 100% Scheme tariff. Limited to R10 500 per family. (Subject to overall day-to-day limit)	Limited to R15 930 per family. (Subject to overall day-to-day limit)
Optometry benefit	Benefits available every 24 months from date of service. **Network Provider** Consultation - One (1) per beneficiary. Frame = R1 000 covered AND 100% of cost of standard lenses (single vision OR bifocal OR multifocal) OR Contact lenses = R1 840 OR **Non-network Provider** Consultation - R365 fee at non-network provider Frame = R750 AND Single vision lenses = R215 OR Bifocal lenses = R460 OR Multifocal lenses = R982.50 In lieu of glasses members can opt for contact lenses, limited to R1 840	Benefits available every 24 months from date of service. **Network Provider** Consultation - One (1) per beneficiary. Frame = R1 040 covered AND 100% of cost of standard lenses (single vision OR bifocal OR multifocal) AND Lens enhancement = R750 covered OR Contact lenses = R2 010 OR **Non-network Provider** Consultation - R365 fee at non-network provider Frame = R780 AND Single vision lenses = R215 OR Bifocal lenses = R460 OR Multifocal lenses = R982.50 Lens enhancement = R562.50 covered In lieu of glasses members can opt for contact lenses, limited to R2 010		Benefits available every 24 months from date of service. **Network Provider** Consultation - One (1) per beneficiary. Frame = R1 040 covered AND 100% of cost of standard lenses (single vision OR bifocal OR multifocal) AND Lens enhancement = R750 covered OR Contact lenses = R2 375 OR **Non-network Provider** Consultation - R365 fee at non-network provider Frame = R780 AND Single vision lenses = R215 OR Bifocal lenses = R460 OR Multifocal lenses = R982.50 Lens enhancement = R562.50 covered In lieu of glasses members can opt for contact lenses, limited to R2 375
Basic radiology and pathology	Savings first. 100% Scheme tariff. Limited to M = R 3 776, M1+ = R7 554. (Subject to overall day-to-day limit)		Savings first. 100% Scheme tariff. Limited to M = R4 120, M1+ = R8 170. (Subject to overall day-to-day limit)	100% Scheme tariff. Limited to M = R6 523, M1+ = R12 839. (Subject to overall day-to-day limit)
Specialised diagnostic imaging (including MRI scans, CT scans and isotope studies. PET scans only included as indicated per option)	100% Scheme tariff. Limited to R16 891 per family. Limited to one (1) scan of the lumbar and cervical spine region for conservative back and neck scans per beneficiary per annum.	**MRI/CT scans: Maximum of two (2) scans per beneficiary:** ▪ Limited to one (1) scan of the lumbar and cervical spine region for conservative back and neck scans per beneficiary per annum. **PET scan:** ▪ One (1) scan per beneficiary. Subject to pre-authorisation.		
Rehabilitation services after trauma	100% Scheme tariff.			
Managed Healthcare - Back and neck preventative programme	Benefits payable at 100% of contracted fee. Subject to pre-authorisation, protocols and DSPs.			
HIV/AIDS	100% Scheme tariff. Subject to pre-authorisation and DSPs.			
Oncology	Oncology programme. 100% of Scheme tariff. Subject to pre-authorisation and DSP.		100% of Scheme tariff. Subject to pre-authorisation and DSP. Access to extended protocols.	
Peritoneal dialysis and haemodialysis	100% Scheme tariff. Subject to pre-authorisation and DSPs.			

Medicine

Benefits mentioned below may be subject to pre-authorisation, clinical protocols, preferred providers, designated service providers, formularies, funding guidelines, the Mediscor Reference Price (MRP) 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 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
CDL & PMB chronic medicine*	100% Scheme tariff. Co-payment of 25% for non-formulary medicine.	100% Scheme tariff. Co-payment of 20% for non-formulary medicine.	100% Scheme tariff. Co-payment of 15% for non-formulary medicine.	100% Scheme tariff. Co-payment of 10% for non-formulary medicine.
Non-CDL chronic medicine	7 conditions. 90% Scheme tariff. Limited to M = R7 690, M1+ = R15 380. Co-payment of 25% for non-formulary medicine.	20 conditions. 90% Scheme tariff. Limited to M = R10 500, M1+ = R21 000. Co-payment of 20% for non-formulary medicine.	20 conditions. 90% Scheme tariff. Limited to M = R16 136, M1+ = R32 272. Co-payment of 15% for non-formulary medicine.	29 conditions. 100% Scheme tariff. Limited to M = R23 000, M1+ = R46 209. Co-payment of 10% for non-formulary medicine.
Biologicals and other high cost medicine	PMBs only as per funding protocol. Subject to pre-authorisation. 100% Scheme tariff.	Subject to pre-authorisation. 100% Scheme tariff. Limited to R192 126 per beneficiary per year.	Subject to pre-authorisation. 100% Scheme tariff. Limited to R384 507 per beneficiary per year.	Subject to pre-authorisation. 100% Scheme tariff. Limited to R569 070 per beneficiary per year.
Acute medicine	Savings first. Limited to M = R2 721, M1+ = R5 631. (Subject to overall day-to-day limit).	Savings first. Limited to M = R3 150, M1+ = R6 300. (Subject to overall day-to-day limit).	Savings first. Limited to M = R2 100, M1+ = R4 725. (Subject to overall day-to-day limit).	Limited to M = R9 809, M1+ = R15 237. (10% co-payment) (Subject to overall day-to-day limit).
Over-the-counter (OTC) medicine Includes sunscreen, vitamins and minerals with NAPPI codes on Scheme formulary	**Member choice: 1. R1 110 OTC limit per family OR 2. Access to full savings for OTC purchases (after R1 110 limit) = self-payment gap accumulation. Subject to available savings.			Savings account.

*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. Medicine claims will be paid directly from Scheme risk.
**The default OTC choice is 1. R1 110 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, formularies, funding guidelines and the Mediscor Reference Price (MRP).

	PACE1	PACE2	PACE3	PACE4
Preventative care **Note: Refer to Scheme rules for funding criteria applicable to each preventative care benefit.**	▪ Flu vaccines. ▪ Pneumonia vaccines. ▪ Travel vaccines. ▪ Paediatric immunisations. ▪ Three baby growth and development assessments per year for children 0-2 years. ▪ Female contraceptives – R2 678 per beneficiary per year. ▪ Intrauterine device (IUD) insertion (consultation and procedure) by a FP or gynaecologist. Once every 5 years. ▪ Preventative dentistry. ▪ Mammogram – females ages 40 and above, once every 24 months. ▪ HPV vaccinations. ▪ Pap smear (procedure and consultation) – age 18 and above, every 24 months. ▪ PSA screening – males ages 50 and above, every 24 months.	▪ Flu vaccines. ▪ Pneumonia vaccines. ▪ Travel vaccines. ▪ Paediatric immunisations. ▪ Three baby growth and development assessments per year for children 0-2 years. ▪ Female contraceptives – R2 678 per beneficiary per year. ▪ Intrauterine device (IUD) insertion (consultation and procedure) by a FP or gynaecologist. Once every 5 years. ▪ Preventative dentistry. ▪ Mammogram – females ages 40 and above, once every 24 months. ▪ PSA screening – males ages 50 and above, every 24 months. ▪ HPV vaccinations. ▪ Bone densitometry. ▪ Pap smear (procedure and consultation) – ages 18 and above, every 24 months. ▪ Glaucoma screening - ages 50 and above, once every 12 months. The benefit is subject to service being received from the contracted Optometrist Network only.		
PREVENTATIVE DENTISTRY				
General full-mouth examination by a general dentist (incl. gloves and use of sterile equipment)	Once a year for members 12 years and above. Twice a year for members under 12 years.			
Full-mouth intra-oral radiographs	Once every 36 months for all ages.			
Intra-oral radiograph	Two (2) photos per year for all ages.			
Scaling and/or polishing	Twice per year (i.e. every 6 months from the date of service) for all ages.			

	PACE1	PACE2	PACE3	PACE4
Fluoride treatment	Twice per year (i.e. every 6 months from the date of service) for all ages.			
Fissure sealing	Up to and including 21 years. Frequency must be in accordance with accepted protocol.			
Space maintainers	Once per space during the primary and mixed denture stage.			

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 pre-authorisation, clinical protocols, preferred providers, designated service providers, formularies, funding guidelines and the Mediscor Reference Price (MRP).

PACE1	PACE2	PACE3	PACE4
100% Scheme tariff. Subject to the following benefits: **Consultations:** ▪ 9 antenatal consultations at a FP OR gynaecologist OR midwife. ▪ 1 post-natal consultation at a FP OR gynaecologist OR midwife. **Ultrasounds:** ▪ 1 x 2D ultrasound scan at 1st trimester (between 10 to 12 weeks) at a FP OR gynaecologist OR radiologist. ▪ 1 x 2D ultrasound scan at 2nd trimester (between 20 to 24 weeks) at a FP OR gynaecologist OR radiologist. **Supplements:** ▪ Any item categorised as a maternity supplement can be claimed up to a maximum of R133 per claim, once a month, for a maximum of 9 months.			

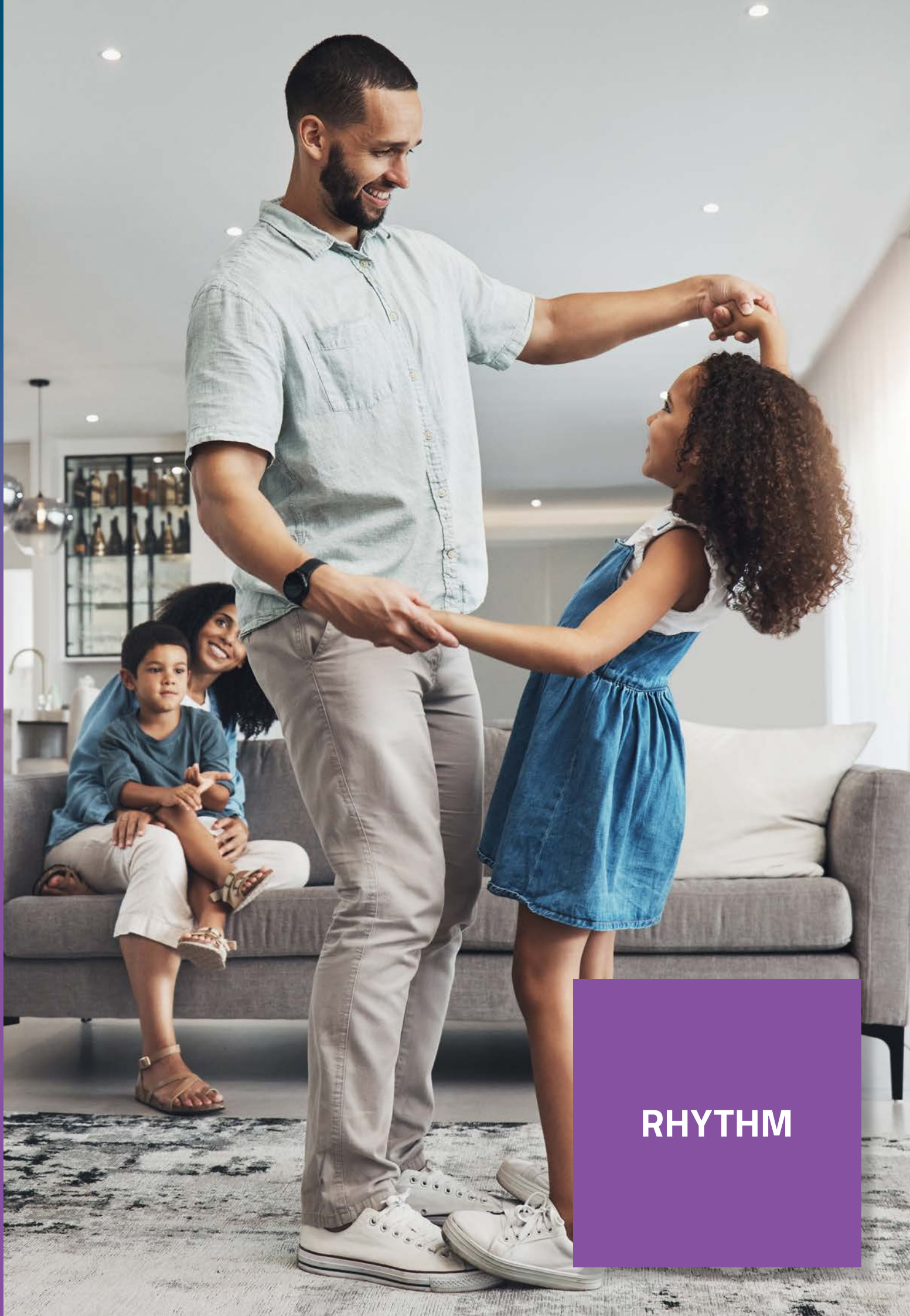
Contributions

		PACE1	PACE2	PACE3	PACE4
Medical Savings Account		**19%**	**14%**	**14%**	**3%**
Principal Member	Risk	R4 099	R6 202	R7 121	R10 033
	Savings	R962	R1 010	R1 159	R310
	Total	**R5 061**	**R7 212**	**R8 280**	**R10 343**
Adult Dependant	Risk	R2 880	R6 082	R5 732	R10 033
	Savings	R675	R990	R933	R310
	Total	**R3 555**	**R7 072**	**R6 665**	**R10 343**
Child Dependant	Risk	R1 034	R1 367	R1 225	R2 350
	Savings	R243	R223	R199	R73
	Total	**R1 277**	**R1 590**	**R1 424**	**R2 423**
Maximum contribution child dependant*		3			
Recognition of a child dependant		Child dependants under the age of 24 years and registered students up to the age of 26 years, in accordance with the Rules, are regarded as child dependants.			

*You only pay for a maximum of three children. Any additional children join as beneficiaries of the Scheme at no additional cost.

ABBREVIATIONS

DBC = Documentation Based Care (Back Rehabilitation Programme); DSP = Designated Service Provider; FP = Family Practitioner or Doctor; HPV = Human Papilloma Virus; M = Member; M1+ = Member and family; MRI/CT scans = Magnetic Resonance Imaging/Computed Tomography scans; MRP = Mediscor Reference Price; NP = Network Provider; PET scan = Positron Emission Tomography scan; PMB = Prescribed Minimum Benefits; PPN = Preferred Provider Negotiators; PSA = Prosate Specific Antigen.



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

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

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) and theatre fees	Approved PMBs at DSPs.	100% Scheme tariff at a DSP hospital.
Take-home medicine	100% Scheme tariff. Medicine for 3 days.	100% Scheme tariff. Medicine for 3 days.
Biological medicine during hospitalisation	Approved PMBs at DSPs.	Limited to R16 648 per family per annum. Subject to pre-authorisation and funding guidelines.
Treatment in mental health facilities	Approved PMBs at DSPs. Limited to a maximum of 21 days per beneficiary per annum.	100% Scheme tariff. Subject to pre-authorisation. Limited to a maximum of 21 days per beneficiary per annum.
Treatment of chemical and substance abuse	100% Scheme tariff (only PMBs). Limited to 21 days per beneficiary per annum. Subject to pre-authorisation and DSP network.	
Consultations and procedures	Approved PMBs at DSPs. Subject to pre-authorisation.	100% Scheme tariff. Subject to pre-authorisation and DSP network.
Surgical procedures and anaesthetics	Approved PMBs at DSPs. Subject to pre-authorisation.	100% Scheme tariff. Subject to pre-authorisation and DSP network.
Organ transplants	100% Scheme tariff (only PMBs).	
Stem cell transplants	100% Scheme tariff (PMBs only).	
Major maxillofacial surgery, strictly related to certain conditions	Approved PMBs at DSPs.	Approved PMBs at DSPs.
Dental and oral surgery (in or out of hospital)	Approved PMBs at DSPs.	Approved PMBs at DSPs.
Prosthesis	100% Scheme tariff. Limited to R61 384 per family. Subject to PMBs at DSP network.	100% Scheme tariff. Limited to R61 384 per family. Subject to preferred providers or DSPs.
Prosthesis – Internal **Note: Sub-limits subject to availability of overall prosthesis limit.** ***Functional: Items used to replace or augment an impaired bodily function.**	Sub-limits per beneficiary per annum: ▪ *Functional R32 550. ▪ Vascular R52 500. ▪ Pacemaker (dual chamber) R49 711. ▪ Endovascular and catheter-based procedures – no benefit. ▪ Spinal including artificial disc R30 416. ▪ Drug-eluting stents – PMBs and DSPs apply. ▪ Mesh R11 124. ▪ Gynaecology/urology R9 188. ▪ Lens implants R6 387 a lens per eye.	
Exclusions (Prosthesis sub-limit subject to preferred provider, otherwise limits and co-payments apply)	Joint replacement surgery (except for PMBs). PMBs subject to prosthesis limits: ▪ Hip replacement and other major joints R31 173. ▪ Knee replacement R39 413. ▪ Minor joints R14 762.	
Prosthesis – External	Approved PMBs at DSPs.	
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.	

	RHYTHM1	RHYTHM2
Orthopaedic and medical appliances	Approved PMBs at DSPs.	100% Scheme tariff. Limited to R7 554 per family.
Basic radiology and pathology	Approved PMBs at DSPs.	100% Scheme tariff.
Specialised diagnostic imaging (including MRI scans, CT scans and isotope studies. Excluding PET scans).	Approved PMBs at DSPs.	100% Scheme tariff. Subject to pre-authorisation.
Oncology	Approved PMBs at DSPs.	Oncology programme. 100% Scheme tariff. Subject to pre-authorisation and DSPs or preferred providers.
Peritoneal dialysis and haemodialysis	Approved PMBs at DSPs.	100% Scheme tariff. Subject to pre-authorisation and DSPs or preferred providers.
Confinements (birthing)	Approved PMBs at DSPs.	100% Scheme tariff.
Midwife-assisted births	PMBs and emergency caesarean sections (C-sections).	100% Scheme tariff. Subject to pre-authoristation, DSPs, protocols and funding guidelines.
Refractive surgery and other procedures done to improve or stabilise vision (except cataracts)	Approved PMBs at DSPs.	Approved PMBs at DSPs.
Supplementary services	Approved PMBs at DSPs.	100% Scheme tariff.
HIV/AIDS	Approved PMBs at DSPs.	100% Scheme tariff. Subject to pre-authorisation and DSPs or preferred providers.
Alternative to hospitalisation (i.e. procedures done in the doctor's rooms)	Approved PMBs at DSPs.	100% Scheme tariff. Subject to pre-authorisation and DSPs or preferred providers.
Advanced illness benefit	Approved PMBs at DSPs.	100% Scheme tariff. Limited to R66 591 per beneficiary per annum. Subject to available benefit, pre-authorisation and treatment plan.
Day procedures	**PMBs in network day hospitals:** Approved PMBs at DSPs. Subject to pre-authorisation, protocols and funding guidelines. **Non-PMBs in network day-hospitals:** 100% Scheme tariff. Subject to approved DSPs and pre-authorisation. Limited to R52 500 per family per annum for non-PMB day procedures. A R2 625 co-payment will be incurred per event if a day procedure is done by a non-DSP provider, or if the procedure is voluntarily done in an acute hospital that is not a day hospital. If the provider is a DSP and does not work in a day hospital, the procedure will be paid in full if it is done in an acute hospital.The non-PMB conditions covered are: ▪ Circumcision ▪ Colonoscopy ▪ Gastroscopy ▪ Myringotomy and grommet insertion ▪ Sterilisation (male and female) ▪ Tonsillectomy	Day procedures performed in a day hospital by a DSP provider will be funded at 100% network or Scheme tariff. A R2 625 co-payment will be incurred per event if a day procedure is voluntarily done by a non-DSP provider, or if the procedure is done in an acute hospital that is not a day hospital. If the provider is a DSP and does not work in a day hospital, the procedure will be paid in full if it is done in an acute hospital.
International medical travel cover	▪ Holiday travel: Limited to 45 days and R500 000 cover for travel to the USA. All other countries covered up to 90 days, with R3 million per family, i.e. member and dependants. ▪ Business travel: Limited to 45 days and R500 000 cover for travel to the USA. All other countries covered up to 45 days, with R3 million per family, i.e. member and dependants.	
Co-payments	Co-payment of up to R13 732 per event for voluntary use of a non-DSP hospital.	

Out-of-hospital benefits

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

Members are required to obtain pre-authorisation for all planned treatments and/or procedures.

	RHYTHM1	RHYTHM2
Overall day-to-day limit	N/A	N/A
FP consultations	Unlimited FP consultations. Subject to Bestmed Rhythm FP network. Pre-approval required after 10th visit. Applicable per family per annum.	Unlimited FP consultations. Subject to Bestmed Rhythm FP network. Applicable per family per annum.
Pharmacy clinic nurse consultations	100% of Scheme tariff. Unlimited primary care nurse consultations (NAPPI code 981078001) at network pharmacies.	No benefit
Casualty and out-of-network FP visits	PMBs only.	100% Scheme tariff. Limited to R1 647 per family.
Specialist consultations	Specialist consultations must be referred by a Rhythm Network Provider. 100% Scheme tariff. Limited to R2 441 per family per year. Subject to Rhythm Specialist Network.	Specialist consultations must be referred by a Rhythm Network Provider. Limited to M = R1 665, M1+ = R2 775. Subject to Rhythm Specialist Network.
Basic and specialised dentistry	Basic dentistry: Subject to Bestmed Rhythm Dental Network Providers. Specialised dentistry: No benefit.	
Medical aids, apparatus and appliances	PMB only.	
Wheelchairs	PMB only.	
Hearing aids	Approved PMBs at DSPs.	
Supplementary services	PMB only.	
Wound care benefit (incl. dressings, negative pressure wound therapy treatment -NPWT- and related nursing services – out-of-hospital)	PMB only.	
Optometry benefit	Benefits available every 24 months from date of service. **Network Provider** One (1) consultation (eye test) at optometrist network per beneficiary per annum. No benefit for spectacle frames, lenses or contact lenses.	Benefits available every 24 months from date of service. **Network Provider** One (1) consultation per beneficiary. Frame = R245 covered (Frame refund value after network discount R184) AND Standard lenses Single vision lenses = R215 OR Bifocal lenses = R460 OR Multifocal lenses = R460 In lieu of glasses members can opt for contact lenses, limited to R700.
Basic radiology and pathology	100% Scheme tariff. Referral by Bestmed Rhythm Network FP or Rhythm Specialist DSP. Subject to Bestmed Rhythm protocols and approved radiology and pathology codes.	
Specialised diagnostic imaging (CT scans and isotope studies. Excluding PET scans).	PMB only.	PMB only.
Rehabilitation services after trauma	PMBs only. Subject to pre-authorisation and DSPs.	
Managed Healthcare - Back and neck preventative programme	Benefits payable at 100% of contracted fee. Subject to pre-authorisation, protocols and DSPs.	
HIV/AIDS	Approved PMBs at DSPs.	100% Scheme tariff. Subject to pre-authorisation and DSPs or preferred providers.
Oncology	Approved PMBs at DSPs.	Oncology programme. 100% Scheme tariff. Subject to pre-authorisation and DSPs or preferred providers.
Peritoneal dialysis and haemodialysis	Approved PMBs at DSPs.	100% Scheme tariff. Subject to pre-authorisation and DSPs or preferred providers.

Medicine

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

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

	RHYTHM1	RHYTHM2
CDL & PMB chronic medicine	100% Scheme tariff. 30% co-payment on non-formulary medicine.	
Non-CDL chronic medicine	No benefit.	No benefit.
Biologicals and other high cost medicine	PMBs only. Subject to pre-authorisation.	
Acute medicine	100% Scheme tariff. Subject to Bestmed formulary.	
Over-the-counter (OTC) medicine **Includes sunscreen, vitamins and minerals with NAPPI codes on Scheme formulary**	No benefit.	100% Scheme tariff. Limited to R666 per family. Subject to preferred provider pharmacy network.

Preventative care benefits

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

	RHYTHM1	RHYTHM2
Preventative care **Note: Refer to Scheme rules for funding criteria applicable to each preventative care benefit.**	▪ Flu vaccines. ▪ Pneumonia vaccines. ▪ Travel vaccines. ▪ Paediatric immunisations. ▪ Three baby growth and development assessments per year for children 0-2 years. ▪ Female contraceptives R2 678 per beneficiary per year. ▪ Intrauterine device (IUD) insertion (consultation and procedure) by a network FP or gynaecologist. Once every 5 years.	▪ Flu vaccines. ▪ Pneumonia vaccines. ▪ Travel vaccines. ▪ Paediatric immunisations. ▪ Three baby growth and development assessments per year for children 0-2 years. ▪ Female contraceptives R2 678 per beneficiary per year. ▪ Intrauterine device (IUD) insertion (consultation and procedure) by a network FP or gynaecologist. Once every 5 years. ▪ HPV vaccinations (Females 9-26 years). ▪ Mammogram (tariff code 34100) – females ages 40 and above, every 24 months. Must be referred by a Bestmed Rhythm Network FP or Rhythm Specialist DSP. ▪ PSA Screening – males ages 50 years and above, every 24 months. ▪ Pap smear – ages 18 and above, every 24 months.

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 pre-authorisation, clinical protocols, preferred providers, designated service providers, formularies, funding guidelines and the Mediscor Reference Price (MRP).

RHYTHM1	RHYTHM2
100% Scheme tariff at DSP network. Subject to the following benefits: **Consultations:** ▪ 6 antenatal consultations at a FP OR gynaecologist OR midwife. **Ultrasounds:** ▪ 1 x 2D ultrasound scan at 1st trimester (between 10 to 12 weeks) at a FP OR gynaecologist OR radiologist. ▪ 1 x 2D ultrasound scan at 2nd trimester (between 20 to 24 weeks) at a FP OR gynaecologist OR radiologist.	100% Scheme tariff at DSP network. Subject to the following benefits: **Consultations:** ▪ 9 antenatal consultations at either a FP OR gynaecologist OR midwife. ▪ 1 post-natal consultation at either a FP OR gynaecologist OR midwife. **Ultrasounds:** ▪ 1 x 2D ultrasound scan at 1st trimester (between 10 to 12 weeks) at a FP OR gynaecologist OR radiologist. ▪ 1 x 2D ultrasound scan at 2nd trimester (between 20 to 24 weeks) at a FP OR gynaecologist OR radiologist. **Supplements:** ▪ Any item categorised as a maternity supplement can be claimed up to a maximum of R133 per claim, once a month, for a maximum of 9 months.

Contributions

		RHYTHM1		
Income level		R0 – R9 000 p.m.	R9 001 – R14 000 p.m.	> R14 001 p.m.
Medical Savings Account			**N/A**	
Principal Member	Risk	R1 432	R1 670	R2 983
	Savings	R0	R0	R0
	Total	**R1 432**	**R1 670**	**R2 983**
Adult Dependant	Risk	R1 432	R1 670	R2 983
	Savings	R0	R0	R0
	Total	**R1 432**	**R1 670**	**R2 983**
Child Dependant	Risk	R590	R710	R1 545
	Savings	R0	R0	R0
	Total	**R590**	**R710**	**R1 545**
Maximum contribution child dependant*		N/A	N/A	N/A
Recognition of a child dependant		Child dependants under the age of 24 years and registered students up to the age of 26 years, in accordance with the Rules, are regarded as child dependants.		

		RHYTHM2		
Income level		R0 – R5 500 p.m.	R5 501 – R8 500 p.m.	> R8 501 p.m.
Medical Savings Account			**N/A**	
Principal Member	Risk	R2 100	R2 523	R3 027
	Savings	R0	R0	R0
	Total	**R2 100**	**R2 523**	**R3 027**
Adult Dependant	Risk	R1 996	R2 397	R2 725
	Savings	R0	R0	R0
	Total	**R1 996**	**R2 397**	**R2 725**
Child Dependant	Risk	R1 264	R1 514	R1 514
	Savings	R0	R0	R0
	Total	**R1 264**	**R1 514**	**R1 514**
Maximum contribution child dependant*			3	
Recognition of a child dependant		Child dependants under the age of 24 years and registered students up to the age of 26 years, in accordance with the Rules, are regarded as child dependants.		

*You only pay for a maximum of three children. Any additional children join as beneficiaries of the Scheme at no additional cost.

ABBREVIATIONS

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

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 Mediscor Reference Price (MRP).
- 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 savings 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 Beat1 N	Beat2 Beat2 N	Beat3/Beat3 N/ Beat3 Plus	Beat4	Pace1	Pace2	Pace3	Pace4	Rhythm1	Rhythm2
Non-formulary co-payment for CDL and PMB conditions	30%	30%	30%	20%	25%	20%	15%	10%	30%	30%
Formulary co-payment for non-CDL conditions	No benefit	No benefit	20%	10%	10%	10%	10%	0%	No benefit	No benefit
Non-formulary co-payment for non-CDL conditions	No benefit	No benefit	30%	20%	25%	20%	15%	10%	No benefit	No benefit

Out-of-hospital radiology and ultrasounds per option

Benefit	Beat1 Beat1 N	Beat2 Beat2 N	Beat3/Beat3 N/ Beat3 Plus	Beat4	Pace1	Pace2	Pace3	Pace4	Rhythm1	Rhythm2
Radiology	PMB only	√	√	√	√	√	√	√	√	√
MRI/CT/Nuclear	√	√	√	√	√	√	√	√	PMB only	PMB only
MRI/CT Scans	√	√	√	√	√	√	√	√	PMB only	PMB only
Maternity benefits - ultrasound scan	√	√	√	√	√	√	√	√	√	√
PET Scans	X	X	X	√	√	√	√	√	X	X

* √ Applicable X Not applicable

Please note: All in-hospital procedures are subject to pre-authorisation.

Chronic Conditions List

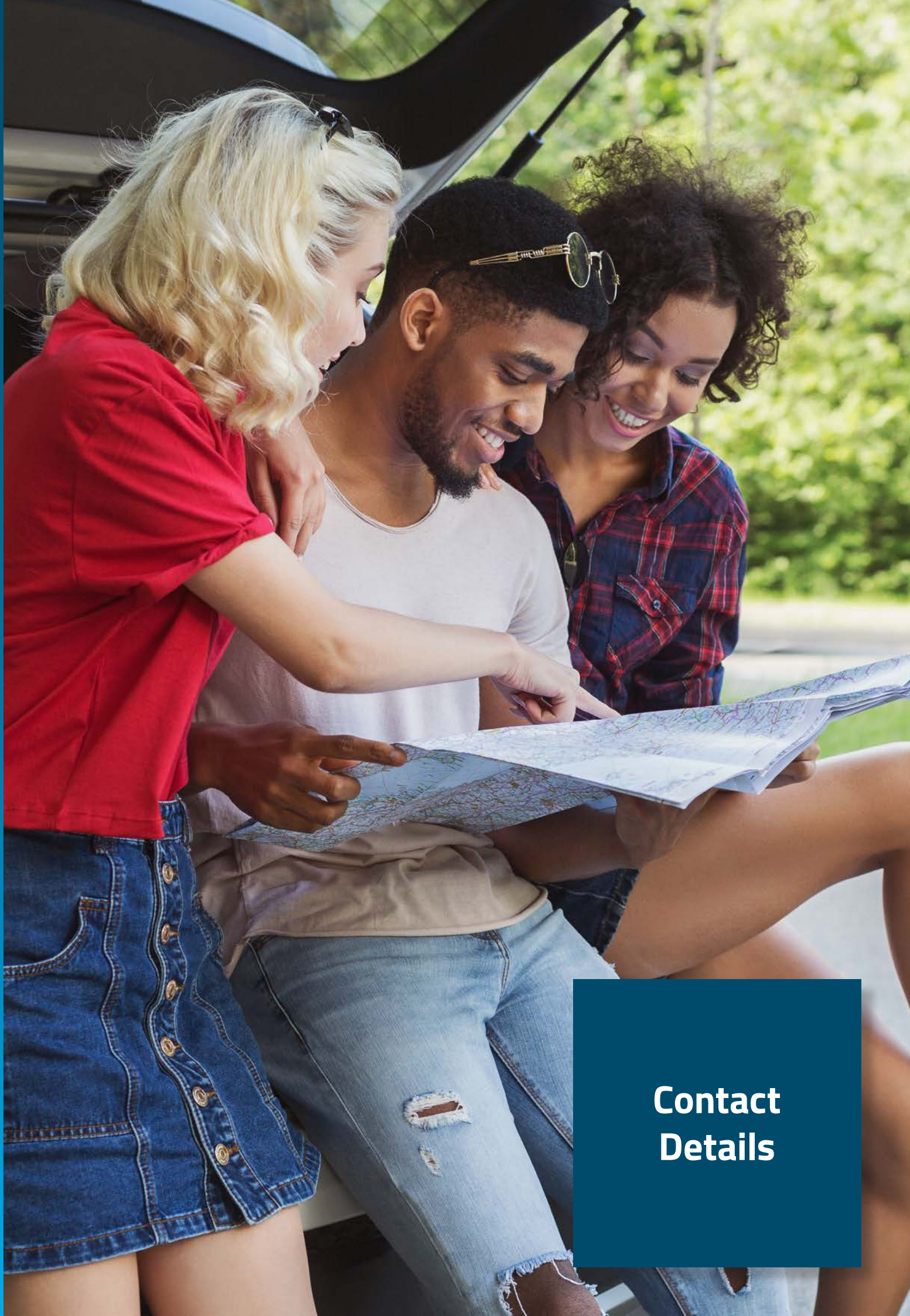
The Chronic Disease List (CDL) provides cover for the 27 listed chronic conditions for which medical schemes must cover the diagnosis, medical management and medicines as published by the Council for Medical Schemes. An additional 18 conditions are covered as Prescribed Minimum Benefits (PMB), where 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	BEAT4	PACE1	PACE2	PACE3	PACE4	RHYTHM1 & 2
Number of non-CDL conditions		0	0	5	9	7	20	20	29	0
Reimbursement for CDL & PMB		100% of Scheme tariff								
Reimbursement for non-CDL		N/A	N/A	80%	90%	90%	90%	90%	100%	N/A
Non-formulary co-payment for CDL and PMB conditions		30%	30%	30%	20%	25%	20%	15%	10%	30%
Formulary co-payment for non-CDL conditions		N/A	N/A	20%	10%	10%	10%	10%	0%	N/A
Non-formulary co-payment for non-CDL conditions		N/A	N/A	30%	20%	25%	20%	15%	10%	N/A
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	√	√	√	√	√	√	√	√	√

		BEAT1	BEAT2	BEAT3	BEAT4	PACE1	PACE2	PACE3	PACE4	RHYTHM1 & 2
CDL 24	Rheumatoid arthritis	√	√	√	√	√	√	√	√	√
CDL 25	Schizophrenia	√	√	√	√	√	√	√	√	√
CDL 26	Systemic lupus erythematosus (SLE)	√	√	√	√	√	√	√	√	√
CDL 27	Ulcerative colitis	√	√	√	√	√	√	√	√	√
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								√	
non-CDL 24	Psoriatic arthritis								√	
non-CDL 25	Psoriasis						√	√	√	
non-CDL 26	Urinary incontinence						√	√	√	
non-CDL 27	Scleroderma								√	
non-CDL 28	Sjögren's disease								√	
non-CDL 29	Trigeminal neuralgia								√	

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

		BEAT1	BEAT2	BEAT3	BEAT4	PACE1	PACE2	PACE3	PACE4	RHYTHM1 & 2
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	Cystic fibrosis	√	√	√	√	√	√	√	√	√
PMB 8	Endometriosis	√	√	√	√	√	√	√	√	√
PMB 9	Female menopause	√	√	√	√	√	√	√	√	√
PMB 10	Fibrosing alveolitis	√	√	√	√	√	√	√	√	√
PMB 11	Graves disease	√	√	√	√	√	√	√	√	√
PMB 12	Hyperthyroidism	√	√	√	√	√	√	√	√	√
PMB 13	Hypophyseal adenoma	√	√	√	√	√	√	√	√	√
PMB 14	Idiopathic trombocytopenic purpura	√	√	√	√	√	√	√	√	√
PMB 15	Paraplegia/quadriplegia	√	√	√	√	√	√	√	√	√
PMB 16	Polycystic ovarian syndrome	√	√	√	√	√	√	√	√	√
PMB 17	Pulmonary embolism	√	√	√	√	√	√	√	√	√
PMB 18	Stroke	√	√	√	√	√	√	√	√	√



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

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

Fax Complaints: 086 673 2466.

Email Complaints: complaints@medicalschemes.co.za

Postal Address:
Private Bag X34, Hatfield, 0028

Physical Address:
Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue,
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claims@bestmed.co.za (claim submissions)

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Pretoria, 0001, South Africa

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

INTERNATIONAL MEDICAL TRAVEL INSURANCE (EUROP ASSISTANCE)
Tel: 0861 838 333
Claims and emergencies: assist@europassistance.co.za
Travel registrations: bestmed-assist@linkham.com

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

BESTMED HOTLINE, OPERATED BY KPMG
Should you be aware of any fraudulent, corrupt or unethical practices involving Bestmed, members, service providers or employees, please report this anonymously to KPMG.

Hotline:	080 111 0210 toll-free from any Telkom line
Hotfax:	080 020 0796
Hotmail:	fraud@kpmg.co.za
Postal:	KPMG Hotpost, at BNT 371, PO Box 14671, Sinoville, 0129, South Africa

INDIVIDUAL CLIENTS APPLYING FOR NEW MEMBERSHIP AFTER THE FINAL DEBIT ORDER CLOSING DATE, WILL BE SUBJECT TO REGISTRATION DATE CHANGE. PLEASE CONSULT YOUR ADVISOR OR BESTMED FOR MORE INFORMATION.

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

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